MEDICAL HISTORY

Has there been any change in your general health within the past year? ____________ YES NO
Are you under the care of a physician? If yes, for what reason? ____________________ YES NO
When was your last physical exam? ____________________________
Have you had any serious illness or operations? __________________________________ YES NO

Have you had any of the following problems or diseases:
Rheumatic fever ....YES NO
Rheumatic heart disease ....YES NO
Cardiovascular disease ....YES NO
High blood pressure ....YES NO
Heart attack .... YES NO
Stroke .... YES NO
Congenital heart lesions ....YES NO
Heart murmur .... YES NO
Pacemaker .... YES NO
Artificial implants .... YES NO
Do you get short of breath when you lie down? .... YES NO
Anxiety? .... YES NO
Sinus trouble? .... YES NO
Asthma or hay fever? ....YES NO
Fainting spells? .... YES NO
Seizures? .... YES NO
Diabetes? ....YES NO
Does anyone in you family have diabetes? ....YES NO
Hepatitis, jaundice, or liver disease? ....YES NO
Arthritis? ....YES NO
Stomach ulcers? .... YES NO
Acid reflux, anorexia, or bulimia? .... YES NO
Tuberculosis? .... YES NO
Venereal disease? .... YES NO
HIV or AIDS? .... YES NO
Do you use tobacco? _________ Pipe_______ Cigars_______ Snuff_______ YES NO
Cigarettes __________ How many packs/day? _____________
Have you ever had excessive bleeding from a cut? ....YES NO
Do you bruise easily? ....YES NO
Do you have any blood disorder such as anemia? ....YES NO
Have you had radiation treatment? ....YES NO
Do you wear contact lenses? ....YES NO
(Women) Are you pregnant? ....YES NO
Do you take birth control pills? .... YES NO
Are you taking any medication prescribed by a doctor or over the counter? ....YES NO
If so, what? ____

Are you allergic or have you reacted adversely to:
Local anesthetics ____________
Penicillin ______________
Other antibiotics ____________
Barbiturates, sedatives, or sleeping pills _______________
Aspirin ____________
Codeine ____________
Any other drugs________________
Do you need to be premedicated prior to dental treatment for any reason? YES NO
Do you have a latex allergy? YES NO
Is there any thing else we should know about your medical history? _________________________
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Patient's signature ____