

Medical History

Patients Name: _____

Medical Doctors Name: _____ Date of Last Medical Visit: _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? _____ If yes, give approximate dates _____

Sex: _____ (Women) Are you pregnant? **YES NO** If yes, how many weeks? _____ Nursing? **YES NO**
Taking birth control pills? **YES NO**

Check (✓) yes or no if you have ever had any of the following:

Y N

- Abnormal bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Joints
- Artificial Heart Valve
- Asthma
- Blood Transfusion
- Cancer-Chemotherapy
- Radiation Treatment
- Colitis
- Congenital Heart Defect
- Cosmetic Surgery
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attack

Y N

- Heart Surgery
- Heart Disease
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- HIV
- AIDS
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Rheumatic Fever
- Seizures
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease
- Yellow Jaundice

Allergies

Y N

- Aspirin
- Codeine
- Erythromycin
- Penicillin
- Tetracycline
- Dental Anesthetics
- Metals
- Jewelry
- Latex

Other _____

Please answer the following:

Y N

- Do you smoke or use tobacco?

Medications Currently Taking: (Please List All)

All Cancellations must be given **2 business days** notice unless of extreme emergency. If the appointment is cancelled without 2 business days notice, we will consider it a **BROKEN APPOINTMENT** and a fee will be charged.

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____