MEDICAL HISTORY

ARE YOU ALLERGIC TO OR HAVE REACTIONS TO:					
DENTAL ANESTHETICS	YES	NO	ASPIRIN	YES	NO
PENICILLIN OR OTHER ANTIBIOTICS	YES	NO	IODINE	YES	NO
SULFA DRUGS	YES	NO	METALS (NICKEL, MERCURY)	YES	NO
BARBITUATES, SEDATIVES, SLEEPING PILLS	YES	NO	LATEX RUBBER	YES	NO
OTHER ALLERGIES Please List:	YES	NO			
DO YOU HAVE OR HAVE YOU EVER HAD:					
ABNORMAL BLEEDING	YES	NO	HEPATITIS-TYPE_____	YES	NO
ALCOHOL ABUSE	YES	NO	HERPES	YES	NO
ANEMIA	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS/RHEUMATISM	YES	NO	HPV (human papilloma virus)	YES	NO
ARTIFICAL HEART VALVE	YES	NO	HYPOGLYCEMIA	YES	NO
ARTIFICAL JOINTS	YES	NO	JAUNDICE	YES	NO
ASTHMA	YES	NO	KIDNEY PROBLEMS	YES	NO
BACK PROBLEMS	YES	NO	LIVER DISEASE	YES	NO
BLOOD TRANSFUSION	YES	NO	LOW BLOOD PRESSURE	YES	NO
CANCER-CHEMOTHERAPY	YES	NO	LUNG/BREATHING PROBLEMS	YES	NO
CIRCULATORY PROBLEM	YES	NO	MENTAL HEALTH CARE	YES	NO
COLITIS	YES	NO	MITRAL VALVE PROLAPSE	YES	NO
COLD SORES/FEVER BLISTERS	YES	NO	OSTEOPOROSIS	YES	NO
CORTISONE TREATMENT	YES	NO	PACE MAKER	YES	NO
DIABETES	YES	NO	PERSISTENT COUGH	YES	NO
DRUG ABUSE	YES	NO	RESPIRATORY PROBLEMS	YES	NO
EATING DISORDER	YES	NO	RHEUMATIC FEVER	YES	NO
EPILEPSY/SEIZURES	YES	NO	SCARLET FEVER	YES	NO
FAINTING/DIZZINESS	YES	NO	SINUS PROBLEMS	YES	NO
FREQUENT HEADACHES	YES	NO	SLEEP APNEA	YES	NO
GLAUCOMA	YES	NO	SNORING	YES	NO
HIV/AIDS	YES	NO	STROKE	YES	NO
HAY FEVER	YES	NO	TAKEN FEN-PHEN	YES	NO
HEART DEFECT or MURMUR	YES	NO	THYROID PROBLEMS	YES	NO
HEART PROBLEMS, ATTACK, ANGINA	YES	NO	TONSILITTIS	YES	NO
HEART SURGERY	YES	NO	TUBERCULOSIS	YES	NO
HEMOPHILIA	YES	NO	ULCERS	YES	NO
OTHER MEDICAL CONCERN:	YES	NO	WEIGHT LOSS-UNEXPLAINED	YES	NO
PLEASE LIST ALL MEDICATIONS/VITAMINS/SUPPLEMENTS:					
WOMEN ONLY:					
ARE YOU PREGNANT? YES NO			**ARE YOU TAKING BIRTH CONTROL PILLS/INJECTIONS? YES NO**		
ARE YOU NURSING? YES NO					

I understand that the information that I have given today is correct to the best of my knowledge. This information will be held in the strictest confidence and it is my responsibility to notify the office of any changes in my medical status. I authorize the staff to perform any necessary dental services that I may need during treatment with my informed consent.

SIGNATURE: _____ DATE: _____