

MEDICAL HISTORY

1. **What is the reason for your visit today?** _____
2. **Have you been hospitalized or had emergency treatment in a hospital in the past 5 years?**
Yes No Why? _____
3. **Have you been under a doctor's care in the past 2 years?** Yes No
Why? _____
4. **Have you had problems with prior dental treatment?** Yes No
5. **Are you currently taking the following medications?**

Anticoagulant/Blood Thinner	yes	no	Heart Medication	yes	no
Lung or Breathing Medication	yes	no	Nitroglycerine	yes	no
Cortisone/Steroid	yes	no	Blood Pressure Meds	yes	no
Insulin	yes	no	Aspirin	yes	no
6. **Are you currently taking any other medications?** Yes No
If yes please list: _____
7. **Have you ever taken dietary Fen-phen medications?** Yes No
8. **Are you allergic** (or have you had a bad reaction) **to any medications** or food? Yes No
If yes, please list: Medicine _____ Reaction _____
Medicine _____ Reaction _____
Are you allergic to latex? Yes No Other(s) _____
9. **Do you have or have you had?**

Heart Problem	yes	no	Lung Problem	yes	no	Diabetes	yes	no
Heart Murmur	yes	no	Asthma	yes	no	Ulcers	yes	no
Rheumatic Fever	yes	no	Sinus Problem	yes	no	Arthritis	yes	no
Scarlet Fever	yes	no	Liver Disease	yes	no	Smoke	yes	no
High Blood Pressure	yes	no	Hepatitis/Jaundice	yes	no	Cancer	yes	no
Stroke	yes	no	Alcohol/Drug Problem	yes	no	Radiation	yes	no
Blood Disease/Anemia	yes	no	Psychiatric Treatment	yes	no	Venereal Disease	yes	no
Kidney Disease	yes	no	Epilepsy/Seizures	yes	no	HIV+/ARC/AIDS	yes	no
10. **Have you had placement of an artificial joint, prosthetic heart valve, implant or pacemaker?**
Yes No _____
11. **Are you subject to prolonged bleeding?** Yes No _____
12. **Do you have difficulty opening your mouth or popping/clicking or pain in your jaw joints (TMJ)?** Yes No _____
13. **Do you wear contact lenses?** Yes No _____
14. **Women only:** Are you or could you be pregnant or nursing? Yes No _____
Are you taking birth control pills? Yes No _____
15. **Do you have any other medical condition that we should know about?** _____

Patient/Parent/Guardian Signature _____ Date _____