MEDICAL INFORMATION

Name _____ Date _____

The following confidential information is requested to thoroughly diagnose any relevant health conditions.

1. Are you in good health? Y N
2. Are you now, or have you been under the care of a medical doctor the past two years? Y N

   If yes, for what? _____

   Physician's Name _____ Phone Number _____

   Address _____
3. Are you currently, or have you taken any medications, drugs, or pills in the past two years? Y N

   If yes, list name and dosage _____
4. Do you have any allergies, or are you sensitive to any drugs or materials such as penicillin, novocaine, aspirin, latex, codiene, mercury, or nickel? Y N

   If yes, please list _____
5. Do you bleed excessively after a cut, wound, or surgery? Y N
6. Are you subject to fainting, dizziness, nervous disorders, convulsions, or epilepsy? Y N
7. Have you ever had any breathing difficulty, such as asthma, emphysema, chronic cough, pneumonia, TB, or other lung disorder? Y N
8. Indicate which of the following you have had or have at present (Circle Y or N for each item).

Heart (surgery, disease, attack)	Y	N	Ulcers	Y	N	Blood transfusion	Y	N
Chest pain	Y	N	Diabetes	Y	N	Hemophilia	Y	N
Congenital heart disease	Y	N	Thyroid problems	Y	N	Sickle cell disease	Y	N
Heart murmur	Y	N	Glaucoma	Y	N	Bruise easily	Y	N
High blood pressure	Y	N	Contact lenses	Y	N	Liver disease	Y	N
Mitral valve prolapse	Y	N	Hives	Y	N	Yellow jaundice	Y	N
Artificial heart valve	Y	N	Sinus trouble	Y	N	Neurologic disorder	Y	N
Heart pacemaker	Y	N	Radiation therapy	Y	N	Psychiatric care	Y	N
Rheumatic fever	Y	N	Chemotherapy	Y	N	Recent weight loss	Y	N
Arthritis (rheumatism)	Y	N	Tumors	Y	N	Any other condition we should know		
Cortisone medication	Y	N	Hepatitis (A or B)	Y	N	concerning your health	Y	N
Swollen ankles	Y	N	Venereal disease	Y	N	If yes what _____		
Stroke	Y	N	A.I.D.S.	Y	N	_____		
Artificial joints (knee, hand, etc.)	Y	N	HIV positive	Y	N	_____		

9. Do you use more than two pillows to sleep? Y N
10. WOMEN: Are you Pregnant? Y Months_____ N Nursing? Y N Taking birth control pills? Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

HISTORY REVIEW
Doctor Signature _____ Date _____