

Medical History

Are you currently having dental problems? _____

What are your concerns? Circle all that applies: (Pain Avoidance) (Appearance) (Losing Teeth) (Cavities) (Oral Cancer) (Cleaning)

(Gum/Periodontal Disease) (Wasting / Exceeding Dental Ins. Limits) (General Health) (Routine Checkup) (Other) _____

Circle yes or no to the following questions:

1. Are you presently under the care of a physician? Yes No
If so, what is the name of your physician?: _____
2. Have you ever had high blood pressure? Yes No
3. Has a physician ever said you have heart trouble?..... Yes No
4. Do you have Mitral Valve Prolapse? Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? Yes No
6. Have you ever had an anesthetic (either local or general)? Yes No
8. Are you allergic to penicillin, Novocain or any other medication? Yes No
If so, please list? _____
9. Is the patient allergic to anything other than medicine? (e.g. latex or metals)?..... Yes No
If so, please list? _____

Do you have or ever had:

1. Rheumatic fever? Yes No
2. Rheumatic heart disease? Yes No
3. Anemia, leukemia or low platelets? Yes No
4. Epilepsy or convulsions? Yes No
5. Tuberculosis? Yes No
6. Asthma or hay fever? Yes No
7. Diabetes? How long? Yes No
8. Kidney Trouble? Yes No
9. Liver trouble or jaundice? Yes No
10. Thyroid trouble or goiter? Yes No
11. Syphilis? Yes No
12. Fainting or dizziness? Yes No
13. Glaucoma? Yes No
14. Arthritis? Yes No
15. HIV / AIDS? Yes No
16. Stroke? Yes No
17. Stomach Ulcer? Yes No
18. Heart Murmur? Yes No
19. Prostate Trouble? Yes No
20. Hepatitis? Yes No
21. Eczema or Hives? Yes No
22. Psychiatric Treatment? Yes No
23. Are you pregnant? Yes No

Are you now taking:

1. Medication for high blood pressure? Yes No
2. Medication for sleeping? Yes No
3. Cortisone, steroids or ACTH? Yes No
4. Anticoagulants or blood thinner?.. Yes No
5. Tranquilizers or sedatives? Yes No
6. Antibiotics? Yes No
7. Insulin? Yes No
8. Others? Yes No
9. Have you ever taken Fen-Phen?.. Yes No

List any questions: _____

Signature _____

Date: _____

Comments: