

PATIENT'S NAME _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name _____
Address _____

Comments

- 2. Are you under a physician's care? YES NO
Since When _____ Why _____
- 3. When was your last complete physical exam? _____
- 4. Are you taking any medication or substances? YES NO
(If yes, please list medications on the back of this form.)
- 5. Do you routinely take health related substances? YES NO
- 6. Are you allergic to any medications or substances? YES NO
- 7. Do you have any other allergies? YES NO
- 8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? YES NO
- 9. Are you sensitive to any metals or latex? YES NO
- 10. Are you pregnant or suspect you may be? YES NO
- 11. Do you use any birth control medications? YES NO
- 12. Have you ever been treated for or been told you might have heart disease? YES NO
- 13. Do you have a pacemaker or an artificial heart valve implant?
YES NO
- 14. Have you ever had rheumatic fever? YES NO
- 15. Are you aware of any heart murmurs? YES NO
- 16. Do you have high or low blood pressure? YES NO
- 17. Have you ever had a serious illness or major surgery?
YES NO
If so, explain _____
- 18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? YES NO
- 19. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
- 20. Do you have any artificial joints/prosthesis? YES NO
- 21. Do you have any blood disorders, such as anemia, leukemia, etc?
YES NO
- 22. Have you ever bled excessively after being cut or injured?
YES NO
- 23. Do you have any stomach problems? YES NO
- 24. Do you have any kidney problems? YES NO
- 25. Do you have any liver problems? YES NO
- 26. Are you diabetic? YES NO
- 27. Do you have asthma? YES NO
- 28. Do you have epilepsy or seizure disorders? YES NO
- 29. Do you or have you had venereal disease? YES NO
- 30. Have you tested HIV positive? YES NO
- 31. Do you have AIDS? YES NO
- 32. Have you had or do you test positive for hepatitis?
YES NO
- 33. Do you or have you had T.B.? YES NO
- 34. Do you smoke, chew, use snuff or any other forms of tobacco?
YES NO
- 35. Do you consume alcoholic beverages? YES NO
- 36. Do you habitually use controlled substances? YES NO
- 37. Have you had psychiatric treatment? YES NO
- 38. Do you have any disease, condition, or problem not listed?
YES NO
If so, explain _____
- 39. Is there anything else we should know about your health that we have not covered in this form? YES NO
- 40. Would you like to speak to the Doctor privately about any problem?
YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

MEDICAL HISTORY