

MEDICAL HISTORY

Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. **HAVE YOU EVER HAD OR HAVE:**

	YES	NO
1. Asthma, hay fever sinusitis, or other allergies including seasonal and latex		
2. Allergy to penicillin, aspirin, local or general anesthetic, or other drug; specify:		
3. Blood pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid, or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or Jaundice		
9. Epilepsy or nervous disorder		
10. Bleeding or clotting disorder		
11. Arthritis		
12. Venereal Disease, Herpes		
13. Acquired Immune Deficiency Syndrome (AIDS)		
14. Any other illness		
15. Do any wounds heal slowly or present complications?		
16. Are you presently taking any medicine? Specify:		
17. Are you presently under the care of a physician?		
18. When was your last physical exam?		
19. Have you ever been hospitalized? Date: _____ Reason: _____		
20. Have you had X-ray treatments or chemotherapy?		
21. Are you presently on a diet?		
22. Woman () Are you taking birth control pills? () Are you pregnant?		

PATIENT SIGNATURE _____ DATE _____

DOCTOR SIGNATURE _____ DATE _____