MEDICAL HISTORY

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving a blank will indicate a "No" response.

- ☐ *Pre-Med
- ☐ Artificial Joints
- ☐ Smoker
- ☐ HIV+/AIDS
- ☐ Herpes
- ☐ Parkinson's Disease
- ☐ Vertigo
- ☐ Asthma
- ☐ Hepatitis
- ☐ Blood thinning medication
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Bypass
- ☐ Pacemaker
- ☐ Artificial Valve
- ☐ Atrial Fibrillation
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Tumors
- ☐ Cancer/Chemo
- ☐ Radiation Treatment
- ☐ Alzheimer's Disease
- ☐ Liver Disease
- ☐ Kidney Disorder
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Thyroid disorder
- ☐ Diabetes

***Allergies:**

- ☐ Latex
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Tetracycline
- ☐ Clindamycin
- ☐ Codeine
- ☐ Other Antibiotics/Medications

*List of medications (prescription and non-prescription)

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*Please list the name of your Pharmacy, location and phone number:

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*Please list the name, location and phone number of Physician:

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*Are you satisfied with the appearance of your teeth?

_____

*Are you interested in improving the appearance of your teeth?

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