Patient Name _____

Date of Birth _____/_____/_____

# MEDICAL HISTORY

Physician _____

1. When was your last physical exam? _____ Dentist _____
2. Has there been any change in your general health within the past year? _____
3. Are you being treated by a physician for any reason at present? _____

   If yes, who? _____
4. What medicine(s) are you taking now? _____
5. Have you ever been hospitalized for any illness, accident, or surgery? _____

   If yes when and why? _____
8. Women: Are you pregnant now? _____

Do you have or have you had any of the following (Please Check ✓ )

| | YES | NO |
|---|---|---|
| 7. Heart Trouble (including heart murmurs, valve prosthesis/pacemaker | | |
| 8. Rheumatic fever | | |
| 9. High/low blood pressure | | |
| 10. Kidney problems | | |
| 11. Liver disease (hepatitis) | | |
| 12. Jaundice | | |
| 13. Diabetes | | |
| 14. Anemia, Sickle Cell, Iron Deficiency, Etc. | | |
| 15. Prolonged bleeding | | |
| 16. Severe infections | | |
| 17. Epilepsy | | |
| 18. Fainting | | |
| 19. Convulsions | | |
| 20. Pneumonia | | |
| 21. Tuberculosis | | |
| 22. Venereal disease | | |

| | YES | NO |
|---|---|---|
| 23. Arthritis | | |
| 24. Allergy, hay fever, hives | | |
| 25. Asthma | | |
| 26. Sinus problems | | |

Are you allergic to or have you had any unusual reactions to:

| | YES | NO | UNKNOWN |
|---|---|---|---|
| 27. Penicillin | | | |
| 28. Dental local anesthetics | | | |
| 29. Codeine or other narcotics | | | |
| 30. Aspirin | | | |
| 31. Sedatives | | | |
| 32. Sulfa | | | |
| 33. Any other drugs or medicine (Specify) | | | |
| 34. Latex | | | |
| 35. Nickel/Chromium or any other metal | | | |
| 36. Do you have any other disease, condition or emotional problems you would like to bring to our attention? | | | |

_____ _____

Date Signature (self or parent/guardian)

| Medical History Update Comments | Date | Medical History Update Comments | Date |
|---|---|---|---|
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