MEDICAL HISTORY FORM (Page 2)

PATIENT NAME _____ BIRTH DAY _____/_____/_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please be as thorough as possible. Thank you.

Do you have, or have you ever had, the following?

AIDS/HIV Positive	___YES ___NO	Cold Sores	___YES ___NO	Rheumatic Fever	___YES ___NO
Alzheimer's/Dementia	___YES ___NO	Cortisone Medicine	___YES ___NO	Rheumatism	___YES ___NO
Anaphylaxis	___YES ___NO	Leukemia	___YES ___NO	Scarlet Fever	___YES ___NO
Anemia	___YES ___NO	Diabetes	___YES ___NO	Shingles	___YES ___NO
Angina/Chest Pains	___YES ___NO	Drug or Alcohol Addiction	___YES ___NO	Sinus Problems	___YES ___NO
Artificial Heart Valve	___YES ___NO	Epilepsy or Seizures	___YES ___NO	Stomach/Esophagus Disease	___YES ___NO
Congenital Heart Disorder	___YES ___NO	Glaucoma	___YES ___NO	Intestinal Disease	___YES ___NO
Heart Attack/Failure	___YES ___NO	Gastric Bypass/Sleeve	___YES ___NO	Swelling of Limbs	___YES ___NO
Heart Murmur	___YES ___NO	GERD (acid reflux)	___YES ___NO	Thyroid Disease	___YES ___NO
Pacemaker	___YES ___NO	Hepatitis	___YES ___NO	Parathyroid Disease	___YES ___NO
Heart Trouble/Disease	___YES ___NO	Liver Disease	___YES ___NO	Tonsillitis	___YES ___NO
Irregular Heartbeat	___YES ___NO	High Cholesterol	___YES ___NO	Tuberculosis	___YES ___NO
Mitral Valve Prolapse	___YES ___NO	High Blood Pressure	___YES ___NO	Tumors or Growths	___YES ___NO
Previous Infective Endocarditis	___YES ___NO	Low Blood Pressure	___YES ___NO	Ulcers	___YES ___NO
Asthma	___YES ___NO	Hypoglycemia	___YES ___NO	Dry Mouth	___YES ___NO
Breathing Problems	___YES ___NO	Kidney Disease	___YES ___NO	Jaw Joint Pain	___YES ___NO
Emphysema/Lung disease	___YES ___NO	Cancer	___YES ___NO	Frequent Headaches	___YES ___NO
Blood Disorder	___YES ___NO	Chemotherapy	___YES ___NO	Arthritis/Joint Pain	___YES ___NO
Bruise Easily	___YES ___NO	Leukemia	___YES ___NO	Artificial Joint	___YES ___NO
Excessive Bleeding	___YES ___NO	Radiation Treatments	___YES ___NO	Psychiatric Care	___YES ___NO
Hemophilia	___YES ___NO	Osteoporosis	___YES ___NO	Anxiety/Panic Attacks	___YES ___NO

Have you ever had any serious illness not listed above? ___YES ___NO If yes explain _____

_____

OFFICE USE: _____

_____

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the dental office of any changes in my medical status.

Patient Signature _____ DATE _____/_____/_____

Guardian Signature (if under 18) _____ Relationship _____