MEDICAL HISTORY

1. When were your teeth cleaned last?_____ (month/year)
2. Are you having pain or discomfort at this time? ..... YES NO
3. Do you feel very nervous about having dental treatment? ..... YES NO
4. Have you ever had a bad experience in a dental office? ..... YES NO
5. Have you been a patient in the hospital during the past two years? ..... YES NO
6. Have you been under the care of medical doctor during the past two years for other than routine exams, and if so, why? ..... YES NO
7. Are you taking any medicine or drugs? (if so, name) ..... YES NO
8. Are you allergic to (i.e.., itching, rash, swelling, of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any other drugs or medications? _____ ..... YES NO
9. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
10. Have you ever had any of the medical conditions listed below? **Please answer each Yes or No.**

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Failure	☐	☐	Stroke	☐	☐	Chemotherapy	☐	☐	AIDS
☐	☐	Heart Disease/Attack	☐	☐	Kidney Trouble	☐	☐	Liver Disease	☐	☐	Hepatitis A (Infectious)
☐	☐	Angina Pectoris	☐	☐	Ulcers	☐	☐	Arthritis	☐	☐	Hepatitis B (Serum)
☐	☐	High Blood Pressure	☐	☐	Emphysema	☐	☐	Rheumatism	☐	☐	HIV+
☐	☐	Heart murmur	☐	☐	Chronic Cough	☐	☐	Cortisone Medicine	☐	☐	Yellow Jaundice
☐	☐	Rheumatic Fever	☐	☐	Tuberculosis (TB)	☐	☐	Glaucoma	☐	☐	Blood Transfusion
☐	☐	Congenital Heart Lesions	☐	☐	Asthma	☐	☐	Pain in Jaw Joints	☐	☐	Drug Addiction
☐	☐	Scarlet Fever	☐	☐	Hay Fever	☐	☐	Epilepsy or Seizures	☐	☐	Hemophilia
☐	☐	Artificial Heart Valve	☐	☐	Sinus Trouble	☐	☐	Fainting or Dizzy Spells	☐	☐	Syphilis
☐	☐	Heart pacemaker	☐	☐	Allergies or Hives	☐	☐	Sickle Cell Disease	☐	☐	Gonorrhea
☐	☐	Heart/Bypass Surgery	☐	☐	Diabetes	☐	☐	Bruise Easily	☐	☐	Cold Sores
☐	☐	Artificial Joint	☐	☐	Thyroid Disease	☐	☐	Periodontal Disease	☐	☐	Genital Herpes
☐	☐	Anemia	☐	☐	X-ray/Cobalt Treatment	☐	☐	Other	☐	☐	Psychiatric Treatment

11. Physician's Name:_____ Telephone:_____
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
13. Do your ankles swell during the day? ..... YES NO
14. Has your medical doctor ever said you have cancer or a tumor? ..... YES NO
15. Do you have any disease, condition, or problem not listed? ..... YES NO
16. Do you smoke? If so, how much?_____ ..... YES NO
17. WOMEN: Are you pregnant now? ..... YES NO
    Are you taking birth control pills? ..... YES NO

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. If I ever have any changes in my health, or if my medicines change, I will inform the Doctor of Dentistry at my next appointment without fail. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits other wise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent of minor Date Dentist's Signature Date

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Patient Signature	Dr. Signature

MEDICAL HISTORY