MEDICAL HISTORY

Date of Last Physical exam _____

Have you been hospitalized in the past two years?	Yes ☐	No ☐
Are you allergic or sensitive to anything (Drugs, dental anesthetics, penicillin, etc)?	Yes ☐	No ☐
Have you ever taken cortisone or steroids?	Yes ☐	No ☐
Have you ever received a blood transfusion?	Yes ☐	No ☐
Do you get out of breath easily?	Yes ☐	No ☐
Do your ankles swell?	Yes ☐	No ☐
Females only: Are you pregnant?	Yes ☐	No ☐
Do you take birth control pills?	Yes ☐	No ☐

Do you have or Have you had?

Heart trouble, murmur	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Autoimmune Disease	Yes ☐	No ☐	Rheumatic fever	Yes ☐	No ☐
Bleeding problem	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Circulatory problems	Yes ☐	No ☐
Liver disease	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Thyroid disease	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Fainting spells	Yes ☐	No ☐
Kidney disease	Yes ☐	No ☐	Nervous disorders	Yes ☐	No ☐
Radiation therapy	Yes ☐	No ☐	Severe headaches	Yes ☐	No ☐
Are you on Aspirin Therapy	Yes ☐	No ☐			

Indicate any disease, condition, or problem not listed above that you think I should know about

_____

_____

Are you currently taking any drugs, medications or pills, tablets, etc.? Yes ☐ No ☐

If so what? _____

Previous Dentist _____

Date of last Dental visit _____

Date of last Dental cleaning _____

Date of last full mouth series of x-rays _____

Initial concern _____

Patient's (or Guardian's) Signature _____

Date _____

Date	Tooth	Services Rendered