



Medical Health History

Do you or have you had any of the following: Yes No
Heart Problems... Chest Pain... Shortness of breath... Blood pressure problem... Heart murmur... Heart valve problem... Taking heart medication... Rheumatic fever... Artificial heart valve... Blood Problems... Easy bruising... Frequent nosebleeds... Abnormal bleeding... Blood disease (anemia)... Ever require a blood transfusion... Allergy Problems... Hay fever... Sinus problems... Skin rashes... Taking allergy medication... Asthma... Intestinal Problems... Ulcers... Weight gain or loss... Special diet... Constipation/Diarrhea... Kidney or bladder problems... Bone or Joint Problems... Arthritis... Back or neck pain... Joint replacement... Fainting Spells, Seizures or Epilepsy... Strokes... Frequent or severe headaches... Thyroid problems... Persistent cough or swollen glands... Premeditations required by physician... Cancer/Tumor...

Are you allergic, or have you reacted adversely to any of the following? Local anesthetics ("Novocaine")... Penicillin or other antibiotics... Sulfa drugs... Barbiturates, sedatives, or sleeping pills... Aspirin, Acetaminophen or Ibuprofen... Codeine, Demerol or other narcotics... Reaction to metals... Latex or rubber dam... Other...

Notes:

Diabetes... Urinate more than 6 times a day... Thirsty or mouth is dry much of the time... Family history of diabetes... Tuberculosis or other respiratory disease... Do you drink alcohol?... If so, how much?... Do you smoke?... If so, how much?... Hepatitis, jaundice or liver trouble... Herpes or other STD... HIV-positive/AIDS... Glaucoma... Do you wear contact lenses?... History of head injury?... Epilepsy or other neurological disease?... History of alcohol or drug abuse?... Do you have any disease, condition or problem not listed previously that you feel we should know about?... If so, please describe:

During the past 12 months, have you taken any of the following? Antibiotics or sulfa drugs... Anticoagulants (e.g., Coumadin)... High blood pressure medicine... Tranquilizers... Insulin, Orinase or similar drug... Aspirin... Digitalis or drugs for heart trouble... Nitroglycerin... Cortisone (steroids)... Natural remedies... Nonprescription drug/supplements... Other:

Women Are you taking contraceptives or other hormones? Are you pregnant? If so, expected delivery date: Are you nursing? Have you reached menopause? If so, do you have any symptoms?

Notes: Patient/Parent Signature: Dentist Initials: