MEDICAL HISTORY

Has there been any problem in your general health within the last five years? (serious illness, hospitalization, surgery) Yes No
If so, what was the problem? _____

_____

Does your phsician require you to take special medication before dentistry? Yes No If so, what? _____
Do you have any drug allergies or have you ever had an adverse reaction to any medications or substances? Yes No
If yes, please list _____
Do you use any medical devices? Y N What? _____
Is snoring a problem? Y N
Please indicate which if any of the following conditions you have had (estimate year) or presently have:

Head or jaw injury	Y N	Transient ischemic attack (TIA)	Y N	Liver disease / jaundice	Y N
Epilepsy or seizures	Y N	Circulatory problems	Y N	Hepatitis A,B,C, other	Y N
Fainting or dizzy spells	Y N	Vascular stents, shunts or grafts	Y N	Kidney problem	Y N
Glaucoma	Y N	Blood disorders / disease	Y N	Ulcers	Y N
Cosmetic surgery	Y N	Hemophilia	Y N	Special diet	Y N
Sinus trouble	Y N	Anemia	Y N	Digestive disorder	Y N
Heart disease	Y N	Blood thinners	Y N	Stomach problems	Y N
Heart attack	Y N	Bruise easily	Y N	Arthritis / rheumatism	Y N
Angina / chest pain	Y N	Blood transfusion	Y N	Back, neck, joint problems	Y N
High / low blood pressure	Y N	Chemotherapeutic port	Y N	Artificial joints	Y N
Heart murmur	Y N	Abnormal bleeding	Y N	Autoimmune disease	Y N
Mitral valve prolapse (MVP)	Y N	Indwelling catheter	Y N	Allergies	Y N
Rheumatic fever	Y N	Organ transplant	Y N	Diabetes	Y N
Congenital heart lesion	Y N	Lung disease	Y N	Thyroid disease	Y N
Artficial heart valve	Y N	Respiratory problems	Y N	Steroid medication	Y N
Heart pacemaker	Y N	Sleep apnea	Y N	Radiation therapy	Y N
Heart surgery	Y N	Emphysema	Y N	AIDS or HIV positive	Y N
Heart stent	Y N	Persistant cough	Y N	Psychiatric treatment	Y N
Shortness of breath	Y N	Tuberculosis (TB)	Y N	Sexually transmitted disease? (STD)	Y N
Swollen ankles	Y N	Asthma	Y N	Chemical / alcohol dependency	Y N
Stroke	Y N	Hay fever	Y N	Cancer	Y N

Do you have any disease, condition or problem not listed above that you think the doctor should know about? Yes No
Explain: _____

Women: Is there a possibility you may be pregnant? Yes No If yes, how long since 1st day of last menstrual period? _____
Are you using birth control pills, patch or implants? Yes No Are you nursing? Yes No

Would you like a report of significant dental / oral health findings sent to your physician? Yes No
Seemingly unrelated medical conditions past or present can influence dental treatment. Does this questionaire accurately alert us to any medical condition you have had in this regard? Yes No
Do you have any reason to believe you are NOT in good health? _____

Patient Signature _____ Date _____

What tablets, pills or liquids do you take? (including aspirin, vitamins, supplements and herbal medications? For what conditions were they prescribed?

DATE	MEDICATION / CONDITION	NOTES