MEDICAL HISTORY

CHECK ONE

	Yes	No
1. What is your reason for coming to our office? _____		
2. Are you now, or have you been, under the care of a physician during the past five years?	❒	❒
If yes, for what reason? _____		
3. Are you taking any medications or herbal remedies?	❒	❒
If yes, what? frequency? dose? _____		
4. Have you been given steroid (cortisone) therapy within the past year?	❒	❒
5. Are you subject to *(Circle the problem you have):* Fainting, Dizziness, Nervous Disorders, Convulsions, Seizure Disorders?	❒	❒
6. Do you have any artificial joints or bone plates?	❒	❒
If yes, where? _____		
7. Do you have pain, popping or clicking associated with your jaw joints?	❒	❒
8. Have you ever had any breathing difficulty?	❒	❒

If yes, please check:
❒ No problems in past year ❒ Chronic Cough ❒ Pneumonia
❒ Hay Fever ❒ Bronchitis ❒ Tuberculosis
❒ Asthma ❒ Emphysema ❒ Any Lung Disorder

9. Have you ever been treated for or diagnosed as having any of the following illnesses?	❒	❒

If yes, please check:
❒ Heart Trouble ❒ High Blood Pressure ❒ Anemia
❒ Heart Murmur ❒ Low Blood Pressure ❒ Glaucoma
❒ Stroke ❒ Hepatitis or Liver Trouble ❒ Diabetes: ❒ Controlled by Diet
❒ Rheumatic Fever ❒ Kidney Disease ❒ Controlled by Medication

10. Do you have any tendency to prolonged bleeding?	❒	❒
If yes, how? _____		
11. Are you allergic or sensitive to any medications or latex?	❒	❒
If yes, what? _____		
12. Have you ever been sedated for a surgical or medical procedure?	❒	❒
If yes, for what? _____		
13. Have you ever had an unfavorable reaction to a local or general anesthetic?	❒	❒
If yes, what? _____		
14. Do you use *(Circle what you use):* tobacco, alcohol, or drugs? If yes, how much?	❒	❒
15. Are you pregnant or nursing?	❒	❒

(If you are unsure, please check with your physician prior to any surgical procedure)

Certain antibiotics prescribed in this office may interfere with the effectiveness of birth control pills. It is recommended that you use an additional method of birth control during that cycle if antibiotics are prescribed. However, continue the use of your birth control pills as prescribed.

16. Do you have any diseases or medical problems not listed above?	❒	❒
If yes, what? _____		

Height:_____ Weight:_____

Your Physician: _____ Last Seen (date): _____

Your General Dentist:_____ Last Seen (date): _____

Signature of Patient (If under 18, signature of legal guardian): _____

COMMENTS: _____

Updates (date & initial)_____