MEDICAL HISTORY

Welcome! *So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential.*

PATIENT'S NAME: _____

Have you been under the care of a medical doctor during the past two years? ..... Yes No
If yes, for what? _____
Physician's Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

Are you currently taking any medications, drugs or pills? ..... Yes No
If yes, please list name and dosage: _____
_____

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ..... Yes No
If yes, please list: _____

Circle Yes or No to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition ..... Yes / No
Heart Attack ..... Yes / No
Heart Surgery ..... Yes / No
Chest Pain (Angina) ..... Yes / No
Congenital Heart Disease ..... Yes / No
Stroke ..... Yes / No
High Blood Pressure ..... Yes / No
Mitral Valve Prolapse ..... Yes / No
Artificial Heart Valve ..... Yes / No
Rheumatic Fever ..... Yes / No
Heart Murmur ..... Yes / No
Heart Pacemaker ..... Yes / No
Anemia ..... Yes / No
Hemophilia ..... Yes / No
Ulcers ..... Yes / No
Alcoholism ..... Yes / No
Drug Addiction ..... Yes / No
Diabetes ..... Yes / No
Family History of Diabetes ..... Yes / No

Contact Lenses ..... Yes / No
Glaucoma ..... Yes / No
Bruise Easily ..... Yes / No
Emphysema ..... Yes / No
Chronic Cough ..... Yes / No
Tuberculosis (T.B.) ..... Yes / No
Asthma ..... Yes / No
Hay Fever ..... Yes / No
Sinus Trouble ..... Yes / No
Allergies or Hives ..... Yes / No
Liver Disease ..... Yes / No
Hepatitis Type ____ ..... Yes / No
Yellow Jaundice ..... Yes / No
AIDS ..... Yes / No
HIV Positive ..... Yes / No
Venereal Disease ..... Yes / No
Cold Sores/Fever Blisters ..... Yes / No
Blood Transfusion ..... Yes / No
Thyroid Problems ..... Yes / No
Swollen Ankles ..... Yes / No

Cortisone Medicine ..... Yes / No
Arthritis/Rheumatism ..... Yes / No
Fen-Phen or Redox ..... Yes / No
Special or Restricted Diet ..... Yes / No
Latex Sensitivity ..... Yes / No
Cancer ..... Yes / No
Tumors ..... Yes / No
Chemotherapy ..... Yes / No
Radiation Therapy ..... Yes / No
Neurological Disorders ..... Yes / No
Nervous/Anxious ..... Yes / No
Epilepsy or Seizures ..... Yes / No
Fainting or Dizzy Spells ..... Yes / No
Psychiatric/Psychological Care .. Yes / No
Kidney Trouble ..... Yes / No
Artificial Joints or Heart Valves... Yes / No
Sickle Cell Disease ..... Yes / No
Osteoporosis ..... Yes / No
Bone Disease or Bone Cancer... Yes / No

Do you have or have you had any disease, condition or problem not listed ..... Yes No
If yes, please list: _____

Have you ever had prolonged or unusual bleeding? ..... Yes No

Have you ever had a reaction to a local anesthetic? ..... Yes No

Women: Are you pregnant?...Yes No If yes, due date: _____ Nursing?...Yes No

(Please complete the other side)