Medical History

Patient's Name___________________________________ Phone (H)_____________________

Address ___________________________________ Cell _____________________

___________________________________ Email__________________________

Responsible Party of Account________________________ Referred By ____________________

Dental Insurance__________________________________ Employer______________________

Subscriber #_____________________________________ Date of Birth ___________________

SS# of Subscriber_________________________________

Please share with us the names of your family members______________________________________

1. Are you having pain or discomfort at this time?------------------------------ Yes No
2. Do you feel very nervous about having dental treatment?------------------ Yes No
3. Have you had a bad experience in a dentist office? ------------------------ Yes No
4. Have you been a patient in the hospital during the last two years?------ Yes No
5. Have you been under a doctors care during the past two years?-------- Yes No
6. Have you taken medicine or drugs during the past two years?----------- Yes No
7. Are you allergic to or made sick by;
   Penicillin, Aspirin, Codeine, or any other drugs or medication ----------- Yes No
8. Have you ever had any excessive bleeding requiring special treatment? ------- Yes No
9. Circle any of the following that you have or have had in the past:

Heart Failure	Stroke	X-Ray or Cobalt Tx	Blood Transfusion
Heart Disease or Attack	Kidney Trouble	Chemo	Drug Addiction
Angina Pectoris	Ulcers	Arthritis	Hemophilia
High Blood Pressure	Mitral Valve Prolapse	Rheumatism	Venereal Disease
Heart Murmur	Emphysema	Cortisone Medicine	Cold Sores
Congenital Heart Lesions	TB	pain in Joint	Epilepsy or Seizure
Scarlet Fever	Asthma	Organ Transplant	Fainting/Dizzy Spells
Artificial Heart Valve	Hay Fever	Aids	Nervousness
Heart Pacemaker	Sinus Trouble	Hepatitis A (infec)	Psychiatric Treatment
Heart Surgery	Allergies or Hives	Hepatitis B (ser)	Sickle Cell Disease
Artificial Joint	Diabetes	Liver Disease	Bruise Easily
Anemia	Thyroid Disease	Yellow Jaundice	

10. When walking upstairs or taking walks do you have to stop because of shortness of breath or become very tired?--- Yes No
11. Do your ankles swell during the day?--- Yes No
12. Do you use more then 2 pillows to sleep?-- Yes No
13. Have you lost or gained more then 10 pounds in the past year?-------------- Yes No
14. Do you ever wake up from sleep short of breath?--------------------------------- Yes No
15. Are you on a special diet?-- Yes No
16. Has your medial doctor ever said you have cancer or tumor?---------------- Yes No
17. Do you have any disease not listed? Yes No If so please name_________________________
18. Women: Are you pregnant?--- Yes No
    Are you practicing birth control?---------------------------------- Yes No
    Do you anticipate becoming pregnant?-------------------------- Yes No
19. Please list all medications currently taking

All of the proceeding statements are true, if any changes occur, I will inform the dentist at my next appointment.

Date________________________ Signature_____________________________________

Please read and sign back of form