Medical History Patient Name _____ DOB _____

Are you currently having pain or discomfort?	Y	N
Do you feel nervous about having dental treatment?	Y	N
Have you ever had a bad experience in a dental office?	Y	N
Have you been a patient in the hospital during the past two years?	Y	N
Have you been under the care of a medical doctor during the past two years?	Y	N
Have you taken any medications or drugs in the last two years?	Y	N
If so, please list:		
What medications are you currently taking?		
Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?	Y	N
Have you had any excessive bleeding requiring special treatment?	Y	N
Are you currently taking Coumadin, Warfarin or any other blood thinners?	Y	N
Are you currently, or in the past, taken any of the following: Fosamax, Actonel, Boniva, Zometa or Aredia?	Y	N

Circle any of the following, that you have/had:

Heart Failure	Anemia	Allergies or Hives	Hepatitis C
Heart Disease or Attack	Stroke	Diabetes	Yellow Jaundice
Angina Pectoris	Kidney Trouble	Thyroid Disease	Blood Transfusion
High Blood Pressure	Ulcers	Arthritis	Drug Addiction
Low Blood Pressure	Alcoholism	Rheumatism	Hemophilia
Heart Murmur	Bruise Easily	Cortisone Medicine	Genital Herpes
Rheumatic Fever	Pain in Jaw Joints	Glaucoma	Cold Sores
Congenital Heart Lesions	Emphysema	Radiation or Cobalt	Epilepsy or Seizures
Artificial Heart Lesions	Cough	Chemotherapy	Fainting or Dizzy Spells
Heart Pacemaker	Tuberculosis (TB)	AIDS Related complex (ARC)	Nervousness
Heart Surgery	Asthma	AIDS	Psychiatric Treatment
Congenital Defects/Valve	Hay Fever	Hepatitis A (infectious)	Sickle Cell Disease
Artificial Joints Endocarditis	Sinus Trouble	Hepatitis B (serum)	Venereal Disease

When you walk up-stairs or take a walk, do you ever have to stop because of chest pain or shortness of breath, or because you are very tired?	Y	N
Do your ankles swell during the day?	Y	N
Do you use more than 2 pillows to sleep?	Y	N
Have you lost or gained more than 10 pounds in the past year?	Y	N
Do you ever wake up from sleep short of breath?	Y	N
Are you on a special diet?	Y	N
Has your medical doctor ever said you have cancer or a tumor?	Y	N
Do you have any disease, conditions, or problems not listed?	Y	N
If so, please list:		
Have you ever had tonsillectomy (tonsils taken out?)	Y	N

Please circle any of the following childhood diseases you have had?

Measles Chicken Pox Mumps Whooping Cough Scarlet Fever Scarlatina Diphtheria Tonsillitis

Do you use any of the following products?

Cigarettes Alcohol Cigars Chewing Tobacco Pipe Snuff

Are you taking birth control pills?	Y	N
Do you anticipate on getting pregnant?	Y	N

When was your last dental cleaning and exam?

Is there anything you would like to change about your smile?

To my knowledge, the above information is correct

Signature_____Date_____