MEDICAL HISTORY

Please mark "YES or "NO" for each question

Patients Name _____Age _____Date_____

Height _____ Weight _____ BP / P

Have you had an **ALLERGY / ADVERSE REACTION** to any type of **food** or **medication**?

- _____
- _____
- _____
- _____

Are you currently taking any **drugs** or **medication** including **herbal medication**.

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

	YES	NO	NOTES:		YES	NO	NOTES:
Diabetes				Radiation Treatment			
Heart Disease				Anemia			
Chest Pain				Bleeding Problems			
Mitral Valve Prolapse				Stomach Ulcers			
Rheumatic Fever				HIV or AIDS			
High Blood pressure				Tumors / Growths			
Low Blood pressure				Chemotherapy			
Artificial Heart Valve				Hepatitis A B or C			
Pacemaker				Jaundice			
Stroke				Thyroid Disease			
Bruising				Kidney Disease			
Glaucoma				Swollen ankles			
Fainting Spells				Artificial Joint			
Asthma				Seizures (epilepsy)			
Lung Disease				Cancer			
Tuberculosis				Arthritis			
Hay Fever / Sinus				Liver Disease			
Snoring				Delayed Healing			
Shortness of Breath				Alcohol / Drug abuse			

Have you ever had any adverse reaction to any form of anesthesia? YES or NO _____
Have you ever had or been treated for pain in your jaw or TMJ? YES or NO_____
Have you had any unusual problem with previous dental work? YES or NO_____
Is this visit a result of an accident? YES or NO please indicate "Date" and "Time" with a brief description.

_____
_____
_____

Do you smoke or use any other form of tobacco? YES or NO
WOMEN: Are you taking Birth Control Pills? YES or NO
Are you pregnant or think you may be? YES or NO
Are you nursing? YES or NO

Do you have any other disease, condition or problem that is not listed above that we should know about Prior to treatment? YES or NO _____

I hereby certify that the above information is accurate and complete to the best of my knowledge.

PATIENT or GUARDIAN'S SIGNATURE: _____DATE:_____