MEDICAL HISTORY

Patient Name_____

Date of Birth _____ Age _____ Weight _____ Height _____

EMERGENCY INFORMATION

Physician _____ Telephone _____

Relative Name _____ Relationship _____

Address _____ Telephone _____

Circle

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you ever had a bad experience in the dentistry office? What? _____ YES NO
3. Have you been a patient in the hospital during the past two years? For what? YES NO
_____
4. Have you been under the care of a medical doctor during the past two years? For what? YES NO
_____
5. Have you taken any medicine or drugs during the past two years? What? YES NO
_____
6. Have you ever taken any bisphosphonate medication (Boniva, Aredia, Zometa, Fosamax, Actonel, Didronel, Skelid) for osteoporosis, bone disease, or cancer? _____ YES NO
7. Have you taken Viagra, Levitra, or Cialis in the past 48 hours? _____ YES NO
8. 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? If so, what YES NO
_____
9. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO

10. Please circle YES or NO to the following:

Heart Failure	YES	NO	Stroke	YES	NO	Chemotherapy			Blood Transfusion	YES	NO
Heart Disease or	YES	NO	Kidney Trouble	YES	NO	(Cancer, Leukemia)	YES	NO	Drug Addiction	YES	NO
Attack (Chest Pains)			Ulcers	YES	NO	Arthritis	YES	NO	Hemophilia	YES	NO
High Blood Pressure	YES	NO	Emphysema	YES	NO	Rheumatism	YES	NO	Venereal Disease	YES	NO
Heart Murmur	YES	NO	Cough	YES	NO	Cortisone Medicine	YES	NO	(Syphilis, Gonorrhea)	YES	NO
Rheumatic Fever	YES	NO	Tuberculosis	YES	NO	Glaucoma	YES	NO	Cold Sores	YES	NO
Congenital Heart Lesions	YES	NO	Asthma	YES	NO	Pain in Jaw Joints	YES	NO	Genital Herpes	YES	NO
Scarlet Fever	YES	NO	Hay Fever	YES	NO	AIDS	YES	NO	Epilepsy or Seizures	YES	NO
Artificial Heart Valve	YES	NO	Sinus Trouble	YES	NO	AIDS Related Complex	YES	NO	Fainting or DizzySpells	YES	NO
Heart Pacemaker	YES	NO	Allergies or Hives	YES	NO	HIV Positive	YES	NO	Nervousness	YES	NO
Heart Surgery	YES	NO	Diabetes	YES	NO	Hepatitis A (infectious)	YES	NO	Psychiatric treatment	YES	NO
Artificial Joint	YES	NO	Alcoholism	YES	NO	Hepatitis B (serum)	YES	NO	Sickle Cell Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Thyroid Disease	YES	NO	Liver Disease	YES	NO	Bruise Easily	YES	NO
Anemia	YES	NO	Radiation or	YES	NO	Chronic Bronchitis	YES	NO	Allergic to Sulfa	YES	NO
			Chronic Bronchitis	YES	NO	Yellow Jaundice	YES	NO	eggs	YES	NO
									latex	YES	NO
									soy beans	YES	NO

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest. or shortness of breath, or because you are very tired? ..... YES NO
12. Do your ankles swell during the day? ..... YES NO
13. Do you use more than 2 pillows to sleep? ..... YES NO
14. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
15. Do you ever wake up from sleep short of breath? ..... YES NO
16. Are you on a special diet? ..... YES NO
17. Do you take diet pills (i.e. Phen Fen)? ..... YES NO
18. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
19. Do you have any disease, condition, or problem not listed? ..... YES NO
20. WOMEN: Are you pregnant now? ..... YES NO
    Is there a possibility you are pregnant: ..... YES NO
    Are you nursing? ..... YES NO
    Are you taking any oral contraceptives ..... YES NO
21. Are you wearing contact lenses? ..... YES NO
22. Do you smoke? How much? _____ YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_____ _____

Date Signature of Patient, Parent or Guardian

.....

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	BP	Pulse	Resp.	NPO	6 hrs
_____	_____			YES	NO
_____	_____			YES	NO
_____	_____			YES	NO
_____	_____			YES	NO
_____	_____			YES	NO
_____	_____			YES	NO