Patient Name ______________________________ Date of Birth __________________________

Family Physician ___________________________ Office Phone __________________________

			DOCTOR COMMENTS
Have you had a medical exam in the last 12 months?	□ Yes	□ No	
Date of last exam _____________________________			
Have there been any changes in your general health within the past year?	□ Yes	□ No	
Have you ever been hospitalized?	□ Yes	□ No	
Are you now receiving medical treatment?	□ Yes	□ No	
Are you presently taking any form of medications?	□ Yes	□ No	
Have you ever been diagnosed or treated for Cancer?	□ Yes	□ No	
Have you ever had heart problems or heart disease?	□ Yes	□ No	
Do you or have you ever taken illegal drugs?	□ Yes	□ No	
Have you ever taken diet pills?	□ Yes	□ No	
Do you smoke or chew tobacco?	□ Yes	□ No	
Would you like to speak to the dentist privately?	□ Yes	□ No	

Are you allergic to or have you had reactions to:

Local Anesthetics	□ Yes	□ No	Antibiotics	□ Yes	□ No
Sulpha Drugs	□ Yes	□ No	Sedatives	□ Yes	□ No
Iodine	□ Yes	□ No	Asprin/Codeine	□ Yes	□ No
Metals	□ Yes	□ No	Latex Rubber	□ Yes	□ No
Specific Foods	□ Yes	□ No	Flavors (e.g. Mint)	□ Yes	□ No

Other ____

WOMEN ONLY:

Are you pregnant or think you are pregnant?	□ Yes	□ No
Are you nursing?	□ Yes	□ No
Are you taking oral contraceptives?	□ Yes	□ No

Have you ever had/or been treated for:

High Blood Pressure	□ Yes	□ No	Tonsillitis/Strep Throat	□ Yes	□ No
Low Blood Pressure	□ Yes	□ No	Prolonged Bleeding	□ Yes	□ No
Swollen Ankles/Feet/Hands	□ Yes	□ No	Hemophilia	□ Yes	□ No
Cortisone Treatment	□ Yes	□ No	AIDS/HIV infection	□ Yes	□ No
Kidney Problems	□ Yes	□ No	Sexually Transmitted Disease	□ Yes	□ No
Diabetes	□ Yes	□ No	Fainting/Dizzy Spells	□ Yes	□ No
Contact Lenses	□ Yes	□ No	Epilepsy/Seizures	□ Yes	□ No
Glaucoma/Eye Problems	□ Yes	□ No	Frequently Tired	□ Yes	□ No
Asthma	□ Yes	□ No	Anxiety/Nervousness	□ Yes	□ No
Shortness of Breath	□ Yes	□ No	Stomach Troubles/Ulcers	□ Yes	□ No
Persistent Cough	□ Yes	□ No	Drug Addiction	□ Yes	□ No
Sinus Troubles/ Colds	□ Yes	□ No	Alcohol Dependence	□ Yes	□ No
Cold Sores/Fever Blisters	□ Yes	□ No	Psychiatric Care	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Recent Weight Loss/Gain	□ Yes	□ No
Emphysema /Bronchitis	□ Yes	□ No	Skin Problems	□ Yes	□ No
Frequent Headaches	□ Yes	□ No	Frequent Earaches	□ Yes	□ No
Allergies/Hay fever	□ Yes	□ No	Hives/Skin Rash	□ Yes	□ No

Eating Disorders	□ Yes	□ No	Rheumatic/Scarlet Fever	□ Yes	□ No
Liver Problems	□ Yes	□ No	Hepatitis A/B/C	□ Yes	□ No
Arthritis	□ Yes	□ No	Organ Transplant	□ Yes	□ No
Back Problems	□ Yes	□ No	Artificial Joints/Implants	□ Yes	□ No
Anemia	□ Yes	□ No	Blood Transfusion	□ Yes	□ No
Excessive Bruising	□ Yes	□ No			

I CERTIFY THAT THE ABOVE INFORMATION IS COMLETE AND ACCURATE

Patient or Parent/Guardian Signature_________________________________ Date ___________________

Treating Dentist's Signature _____________________________________ Date____________________

Initial Health Status:

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Initial Medication List

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