Patient Name: _____ Today's Date: _____

Name of Physician: _____ Date of last exam: _____

Medical/Dental History

Do you have, or have you had any of the following?

High Blood Pressure	Y	N	Tuberculosis	Y	N
Angina/Chest Pain	Y	N	Thyroid Problems	Y	N
Cardiac Pacemaker	Y	N	Immune Disorder/HIV	Y	N
Heart Attack	Y	N	Glaucoma	Y	N
Heart Disease	Y	N	Diabetes	Y	N
Heart Murmur/MVP	Y	N	Kidney Disease	Y	N
Stroke	Y	N	Liver Disease/Hepatitis	Y	N
Faintness/Seizures	Y	N	Stomach Problems	Y	N
Respiratory/Lung Condition	Y	N	Arthritis	Y	N
Shortness of Breath	Y	N	Recent Weight Gain/Loss	Y	N
Radiation Therapy	Y	N	Use Tobacco Products	Y	N
Cancer	Y	N	Diet Medications	Y	N
Bone diseases (Osteoporosis, Paget's disease,			Prolonged Bleeding	Y	N
Metastatic Cancer, Multiple Myeloma, or other			Hearing Problems	Y	N
bone conditions)	Y	N	Joint Replacement	Y	N
Bisphosphonate medications?	Y	N	Artificial Heart Valve	Y	N

Women: Are you currently pregnant or nursing? _____

Are you allergic or have you reacted adversely to:

Local anesthetics (Novocaine)	Y	N	Barbiturates/Sedatives	Y	N
Penicillin or other antibiotics	Y	N	Codeine or pain meds	Y	N
Aspirin, Tylenol, Ibuprofen	Y	N	Latex	Y	N

Other (please list):_____

Do you have any other disease, condition, or problem not listed above? _____

Have you had any trouble associated with previous dental treatment? Y N

Are you currently taking any drugs, medications, or supplements? Please list below Y N

Name of Medication	Dose/Frequency	Reason for Taking

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

Signature: _____ Date: _____