Medical/Dental History

(Please Print)

Name _____

1. Are you now or have you been under the care of a physician during the last 5 years ? ____Yes ____No
   If yes, for what ? _____

2. Do you take any medicine, including birth control pills, on a regular basis ? ..... ____Yes ____No
   If yes, what ? _____

3. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy ? ... ____Yes ____No

4. Have you ever had any breathing difficulty such as asthma, bronchitis, emphysema, chronic cough, pneumonia, TB, Black Lung or any lung disorder ? ..... ____Yes ____No

5. Have you ever had any of the following illnesses ? If "yes". Please check

____Heart trouble	____Hepatitis or Liver trouble	____Diabetes
____Stroke	____ AIDS/HIV positive	____Anemia
____Rheumatic fever	____Kidney disease	____Glaucoma
____Heart murmur	____High or low blood pressure	____Sinus problems
____Mitral valve prolapse	____Artificial joints	____TMJ problems

6. Are you subject to profuse bleeding ? ..... ____Yes ____No

7. Are you sensitive or allergic to any medications ? ..... ____Yes ____No
   If yes, what ? _____

8. Can you take penicillin, aspirin, codeine or Novocaine ? ..... ____Yes ____No

9. Have you ever had radiation treatment about the head, neck or jaws ? ..... ____Yes ____No

10. Women: Are you pregnant ? ..... ____Yes ____No

11. Do you smoke ? ____Yes ____No If yes, how much and for how long ? _____

12. Please describe any current medical treatment, planned operations, or any medical or dental information that may possibly affect your care.

    _____

    _____

13. Please briefly describe the dental problem(s) for which you have scheduled to be seen and any concerns you may have in regard to your dental condition. _____

    _____

    _____

Signature _____ Date _____