MEDICAL HISTORY

Name: (F) _____(M) _____ (Last) _____

Date of Birth: _____

Physician's Name: _____ Date of Last Exam: _____

Address: _____Phone: _____

Have you been hospitalized or had major surgery? Yes No List: _____
Do you use Tobacco? Yes No Specify_____
Do you use alcohol? Yes No Specify Usage _____
Are you taking illicit drugs? Yes No Specify _____
Are you taking any medication or vitamins? Yes No
Please List: _____
_____

Are you allergic to any of the following? [ ] No known Allergies
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local anesthetics
[ ] Other ……..Please List & Explain _____

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

AIDS/HIV Positive _____	Yes	No	Herpes _____	Yes	No
Anemia _____	Yes	No	High Blood Pressure _____	Yes	No
Arthritis/Gout _____	Yes	No	Hives/Rash _____	Yes	No
Artificial Heart Valve_____	Yes	No	Hypoglycemia _____	Yes	No
Artificial Joint _____	Yes	No	Kidney Problems _____	Yes	No
Asthma _____	Yes	No	Leukemia _____	Yes	No
Blood Disease _____	Yes	No	Liver Disease _____	Yes	No
Cancer _____	Yes	No	Low Blood Pressure _____	Yes	No
Chemotherapy _____	Yes	No	Lung Disease _____	Yes	No
Congenital Heart Disorder_____	Yes	No	Mitral Valve Prolapse _____	Yes	No
Diabetes _____	Yes	No	Pain In Jaw Joints _____	Yes	No
Drug Addiction _____	Yes	No	Psychiatric Care _____	Yes	No
Epilepsy/Seizures _____	Yes	No	Radiation Treatments _____	Yes	No
Excessive Bleeding_____	Yes	No	Rheumatic Fever _____	Yes	No
Fainting Spells/Dizziness _____	Yes	No	Scarlet Fever _____	Yes	No
Frequent Headaches _____	Yes	No	Shingles _____	Yes	No
Heart Attack/Failure _____	Yes	No	Sinus Problems _____	Yes	No
Heart Murmur _____	Yes	No	Stomach Disease _____	Yes	No
Heart Pace Maker _____	Yes	No	Stroke _____	Yes	No
Hepatitis A_____	Yes	No	Thyroid Disease _____	Yes	No
Hepatitis B or C _____	Yes	No	Tuberculosis _____	Yes	No

Have you ever had any serious illness not listed above? _____

Women:
Pregnant/Trying …. Yes No Taking oral Contraceptives …. Yes No Nursing …. Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT/GUARDIAN'S SIGNATURE _____ DATE_____