MEDICAL HISTORY

Name: ___________________________

Are you being treated for any medical condition at the present or have you been treated within the last year? Yes___ No___ If so, for what reason? ____

Have you been hospitalized, had an operation, or have experienced a serious illness in the last two years? Yes___ No___ If so, why?____

Are you currently taking any medications, non-prescription drugs, or herbal supplements? Yes__No___ If yes, what are they?____

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Do you have any allergies or react adversely to any drug or medicine? Yes___No__

If yes, what are they?____

Do you have any food allergies? Please list them. ____

Do you bruise or bleed easily for more than a few minutes? ______________________________________

Do you have any disease or condition that the dentist should be made aware of? Yes___No__

Including any blood disorders? ____

Do you have a prosthetic or artificial joint? Yes___No__

Do you smoke? Yes___No___ If yes, how many per day?________________________

Women: Are you or may you be pregnant? Yes___No___ If yes, which trimester?___________

Please check any applicable below:

___Heart trouble/heart attack	___Stomach trouble/Ulcer	___Arthritis
___High/Low blood pressure	___Hepatitis/jaundice	___Glaucoma
___Stroke/Chest pain	___Tuberculosis/lung problems	___Epilepsy
___Diabetes	___Kidney disease	___Asthma
___Blood disorders/Anemia	___Thyroid/ Hypo or Hyper	___Cancer
___Rheumatic fever	___Clinically depressed	___STD

_____________________________________ ___________________

Signature **Date**