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?_____

_____

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?_____

Have you ever had any of the following:

___Heart trouble/heart attack	**___Stomach trouble/Ulcer**	**___Arthritis**
___High/Low blood pressure	**___Jaundice or Hepatitis (A/B/C)**	**___Glaucoma**
___Stroke/Chest pain	**___Tuberculosis/lung problems**	**___Epilepsy**
___Diabetes	**___Kidney disease**	**___Asthma**
___Blood disorders/Anemia	**___Thyroid/ Hypo or Hyper**	**___Cancer**
___Rheumatic fever	**___Clinically depressed**	**___Radiation to the head or neck**

_____ _____

Signature **Date**