MEDICAL HISTORY

Patient: _____ Family Dr: _____ Dr. Phone number _____

Email Address: _____ Referred by: _____

Emergency Contact (name)_____ phone number_____

Are you happy with your smile? _____

YES	NO	Question
[ ]	[ ]	1. Are you presently in good health?
[ ]	[ ]	2. Have you been under the care of a physician recently?
[ ]	[ ]	3. Have you ever had a serious illness?
[ ]	[ ]	4. Have you ever had any type of allergy?
[ ]	[ ]	5. Have you ever had a reaction to any drug?
[ ]	[ ]	6. Are you taking any medication(s) at present? If so, please list.
[ ]	[ ]	7. Have you ever fainted?
[ ]	[ ]	8. Do you bruise easily or have any trouble controlling bleeding?
[ ]	[ ]	9. Do you ever get chest pain?
[ ]	[ ]	10. Have you ever had heart disease, a heart attack, or a stroke?
[ ]	[ ]	11. Do you have high blood pressure?
[ ]	[ ]	12. Have you ever had a problem with a heart valve or endocarditis?
[ ]	[ ]	13. Do you have a pacemaker?
[ ]	[ ]	14. Have you ever had a joint replacement surgery?

Continue→

YES	NO	
[ ]	[ ]	15. Are you diabetic? If so, type 1 or 2?
[ ]	[ ]	16. Do you have breathing problems, COPD, or asthma?
[ ]	[ ]	17. Do you have any kidney problems/kidney disease?
[ ]	[ ]	18. Have you ever had Hepatitis A, B, or C? Liver Disease?
[ ]	[ ]	19. Do you have HIV or AIDS?
[ ]	[ ]	20. Have you ever had a seizure or been diagnosed with epilepsy?
[ ]	[ ]	21. Do you take cortisone medication or any other steroids?
[ ]	[ ]	22. Have you ever had any injury, surgery, or x-ray therapy to the face or jaws?
[ ]	[ ]	23. Have you ever been diagnosed/treated for any cancers?
[ ]	[ ]	24. Women – Are you pregnant? Are you taking oral contraceptives? Are you nursing?
[ ]	[ ]	25. Do you smoke? Use any tobacco products? If so, how much?
[ ]	[ ]	26. Do you use alcoholic beverages? How frequently?
[ ]	[ ]	27. Do you take any non-prescription drugs/medication?
[ ]	[ ]	28. Do you have anxiety about dental treatment?
[ ]	[ ]	29. Do you have any Dietary Restrictions?

By signing below I certify that the information above is correct to the best of my knowledge

Signature of Patient **Date**