3.

MEDICAL HISTORY

In the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health?.. YES ☐   NO ☐

Has there been any change in your general health within the past year? .... YES ☐   NO ☐

My last physical examination was on _____

Are you now under the care of a physician? .... YES ☐   NO ☐

If so, what is the condition being treated? _____

The name and address of my physician is _____

Are you taking any medication? .... YES ☐   NO ☐

Please list medications: _____

Are you pregnant?..................................... YES ☐   NO ☐   Approximate Due Date _____

| Have you ever had or been treated for: | | | Artificial joint....................................... Yes ☐   No ☐ |

Have you ever had or been treated for:

Heart disease .... Yes ☐   No ☐   Artificial joint.. Yes ☐   No ☐

Congenital heart lesions .... Yes ☐   No ☐   Cancer .... Yes ☐   No ☐

Heart murmur .... Yes ☐   No ☐   Jaundice .... Yes ☐   No ☐

Abnormal blood pressure..................... Yes ☐   No ☐   Asthma .... Yes ☐   No ☐

Rheumatic Fever .... Yes ☐   No ☐   Sinus trouble .... Yes ☐   No ☐

Ulcers .... Yes ☐   No ☐   Respiratory ailments .... Yes ☐   No ☐

Tuberculosis .... Yes ☐   No ☐   Hepatitis... Yes ☐   No ☐

Diabetes .... Yes ☐   No ☐   Arthritis .... Yes ☐   No ☐

Epilepsy... Yes ☐   No ☐   Stroke .... Yes ☐   No ☐

Anemia .... Yes ☐   No ☐   Glaucoma.. Yes ☐   No ☐

Chest pain upon exertion .... Yes ☐   No ☐   AIDS or HIV Positive........................... Yes ☐   No ☐

Shortness of breath   STD (Sexually Transmitted Diseases) ..... Yes ☐   No ☐

after mild exercise .... Yes ☐   No ☐

Are you allergic to: ☐ Penicillin   ☐ Codeine   ☐ Local injected anesthetics   ☐ Latex   ☐ Other medications _____

Have you ever been told you need to be pre-medicated for dental treatment? .... Yes ☐   No ☐

Are you subject to prolonged bleeding?... Yes ☐   No ☐

Are you subject to fainting spells? .... Yes ☐   No ☐

Do you have excessive urination and/or thirst? .... Yes ☐   No ☐

Do you smoke?... Yes ☐   No ☐   How many packs a day? _____

DENTAL HEALTH

Reason for today's visit: _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? .... Yes ☐   No ☐

If so, please explain: _____

Have you ever had periodontal (gum) disease?... Yes ☐   No ☐   When? _____

If so, please explain: _____

Have you ever had orthodontic treatment (braces)? .... Yes ☐   No ☐   When? _____

If so, please explain: _____

Please add anything you feel is important: _____

_____

_____

_____

_____

_____   _____
patient (or parent) signature   **date**