Medical history for **Patient Name**:_____

Name of primary physician:_____

Address or telephone number of physician:_____
Please circle "**Yes**" or "**No**" to the following questions. This information will be kept confidential as per our "Notice of Privacy Practices" which accompanies this questionnaire.

Yes..No Are you in good health? If no, why_____

Yes..No Has there been any change in your general health within the past year? If Yes, what_____

_____

Yes..No Are you under the care of a physician now? If so, why_____

List your medications_____

_____

Yes..No Have you ever had any serious illness or operations? If so, what_____
Do you have or have you had any of the following?

Yes..No - Rheumatic Fever
Yes..No - Mitral valve prolapse
Yes..No - High blood pressure
Yes..No - Stroke
Yes..No - Heart murmur or click
Yes..No - Heart attack or disease
Yes..No - Chest pain of angina
Yes..No - Artificial joint or valve
Yes..No - Bleeding or blood disorder
Yes..No - Venereal Disease
Yes..No - Tuberculosis

Yes..No - Hepatitis or liver disease
Yes..No - Asthma
Yes..No - Diabetes
Yes..No - Seizures
Yes..No - Cancer
Yes..No - Frequent headaches
Yes..No - Thyroid condition
Yes..No - Chronic illnesses
Yes..No - Herpes virus (cold sores)
Yes..No - AIDS or HIV+ infection
Yes..No - Radiation or chemotherapy

Yes..No Are you pregnant? If yes, expected delivery date_____
Yes..No Have you ever been told by your physician to have antibiotic coverage before dental cleanings or extractions? If yes, why and which antibiotic _____
Yes..No Are you allergic or sensitive to any of the following?

Yes..No – Local anesthetics ("novocaine")
Yes..No – Penicillin or other antibiotics
Yes..No _ Latex glove allergy
Yes..No - Aspirin, codeine, etc
Yes..No – Other drugs,please specify

Yes..No Have you ever had abnormal bleeding from previous extractions, surgery, or wounds? If yes, what_____
Yes..No Have you ever had surgery or x-ray treatment of a tumor or growth of your head or neck?

Yes..No Do you smoke or use any tobacco products? If yes, what and how much_____

Yes..No Do you use alcohol or any other drugs

Yes..No Are you pleased with the appearance of your teeth? If no, why_____

Yes..No Is there anything else that we should be aware of? If yes, what_____

Date:_____ Signature of patient or parent_____