PATIENT NAME:

1. Have you been under the care of a medical doctor during the past two years? Y N
   If you answered yes, what were you being treated for?

2. Are you allergic to or have you had any adverse reaction to any of the following?

Local Anesthetic	Y	N	Penicillin	Y	N	Latex	Y	N
Nitrous Oxide	Y	N	Erythromycin	Y	N	Gold Jewelry	Y	N
Codeine/Other Narcotics	Y	N	Tetracycline	Y	N	Other Medications	Y	N
Aspirin	Y	N	Sulfa Drugs	Y	N	Other Substances	Y	N
Sedatives/Tranquilizers	Y	N	Motrin	Y	N	Other Antibiotics	Y	N

If you have answered yes to any of the above, please explain. ____

3. Do you have or have you had any of the following?

Pacemaker	Y	N	Congenital Heart Disease	Y	N	High/Low Blood Pressure	Y	N
Rheumatic Fever	Y	N	Artificial Heart Valve	Y	N	Heart Attack/Stroke	Y	N
Mitral Valve Prolaps	Y	N	Artificial Joints	Y	N	Heart Murmur	Y	N

If you have answered yes to any of the above, please explain. ____

4. Are you taking anticoagulants (blood thinners, aspirin) daily? Y N
5. Have you or any family member had (TB) Tuberculosis? Y N
6. Have you had a productive (very deep) cough that has lasted for more than a few weeks? Y N
7. Indicate which of the following you have had previously or have at the present time.

H.I.V	Y	N	Fainting/Dizzy Spells	Y	N	Glaucoma	Y	N
Hepatitis A/B/C	Y	N	Nervous/Anxious	Y	N	Allergies or Hives	Y	N
Hemophilia	Y	N	Psychological Care	Y	N	Sinus Trouble	Y	N
Diabetes	Y	N	Eating Disorder	Y	N	Hay Fever	Y	N
Anemia	Y	N	Stomach Disorder	Y	N	Asthma	Y	N
Alcoholism	Y	N	Radiation Therapy	Y	N	Emphysema	Y	N
Drug Abuse	Y	N	Chemotherapy	Y	N	Liver Disease	Y	N
Kidney Trouble	Y	N	Tumors/Cysts/Cancer	Y	N	Sickle Cell Disease	Y	N
Venereal Disease	Y	N	Thyroid Problems	Y	N	Restricted Diet	Y	N
Neurological Disorder	Y	N	Epilepsy or Seizures	Y	N	Arthritis/Rheumatism	Y	N

8. Are you taking any medications, drugs, or pills now? Y N
   If you answered yes, please list names and dosages. ____
9. Do you have any conditions, diseases, or problems not listed? Y N
   If you answered yes, please list or explain. ____
10. Have you been hospitalized within the last five years? Y N
    If you answered yes, please explain. ____
11. Women: Are you pregnant? Y N Are you nursing? Y N Taking Birth Contol? Y N

I understand the above information is necessary to provide myself with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health.

X ____________________________ _____|_____|_____ X ____________________________

Patient Signature Date Doctor Signature

ALERTS: MEDICAL HISTORY