			OFFICE USE ONLY
PATIENT'S NAME		DATE OF BIRTH	YES NO PRE-MED 0 0 COMMENTS:
PHYSICIAN'S NAME	PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE	
MOST RECENT VISIT TO PHYSICIAN	REASON		
HOW WOULD YOU ASSESS YOUR GENERAL HEALTH? 0 GOOD 0 FAIR 0 POOR			DATE _______________

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
Are you currently seeing a physician for treatment of a recent or ongoing medical condition?	0	0
Have you been hospitalized within the last year? If yes, explain:	0	0
Have you had a serious illness or operation within the last year? If yes, explain:	0	0
Have you ever had any serious medical trouble Associated with any dental experience? If yes, explain:	0	0
Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	0	0

Do you now or have you had any of the following cardio-vascular diseases? **yes** 0 **no** 0

If yes, check any that apply:

0 Heart disease
0 Heart attack
0 Coronary bypass
0 Angina
0 Mitral valve prolapse
0 Hardening of the arteries
0 High blood pressure
0 Stroke
0 Heart murmur
0 Congestive heart failure

0 Rheumatic fever or rheumatic heart disease
0 Congenital heart defects
0 Prosthetic (artificial) heart valves
0 Pacemaker. If yes, date of placement ______________
0 High blood pressure
0 High cholesterol
0 Shortness of breath after mild exercise
0 Shortness of breath when you lie down
0 Swelling of ankles

Diabetes **yes** 0 **no** 0

If yes, do you require insulin?
Type __________ Dose________

Artificial joint(s) **yes** 0 **no** 0

If yes, which joint(s)
____

Hepatitis **yes** 0 **no** 0

If yes, check type:

0 Type A
0 Type B
0 Type C
0 Other
0 Non-specific type
0 Don't know

0 Required a blood transfusion
If yes, when _________________

0 HIV positive
0 Have reason to suspect you have been exposed to the HIV virus

Tuberculosis (TB) **yes** 0 **no** 0

0 Had a TB test?
0 A cough lasting more than three weeks
0 Cough up blood

Check any that apply;

0 Allergies	0 Glaucoma
0 Alzheimer's	0 Heart Disease
0 Anemia	0 Herpes
0 Angina	0 HIV / AIDS
0 Asthma	0 Jaundice
0 Arthritis	0 Joint Replacement
0 Autoimmune	0 Kidney Disease
0 Blood Disorder	0 Organ Transplant
0 Cancer	0 Osteoporosis
0 Chemo Therapy	0 Parkinson's
0 Chronic Sinus	0 Radiation
0 Cirrhosis	0 Treatment
0 Depression	0 Severe Headaches

HEALTH HISTORY

	Yes	No
Do you consider yourself currently under an *abnormally* high amount of stress?	0	0
Have you had an unexplained or unplanned weight loss recently?	0	0

When was your last complete physical exam with your physician, including blood tests? ____________________

	Yes	No
Do you now or have you ever smoked?	0	0

If you currently smoke, how much? _______________
If you were a smoker, when did you quit? __________

	Yes	No
Do you chew tobacco?	0	0

If yes, how often? _________________

	Yes	No
Do you drink alcohol?	0	0

Are you *ALLERGIC* to any of the following (get hives, a rash, have trouble breathing, etc.):

0 Antibiotics (penicillin, tetracycline)
0 Local dental anesthetics (novocain)
0 Codeine
0 Aspirin
0 Barbiturates or sedatives
0 Tranquilizers
0 Others

	Yes	No
Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication?	0	0
Do you have any disease, condition or medical problem not listed you feel we should know about?	0	0

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____
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W O M E N O N L Y

	Yes	No
Are you currently pregnant or nursing?	0	0

If yes, expected delivery date ______________

Please list any prescription and OTC medications that you are currently taking:

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S I G N A T U R E S

Today's Date

NOTES:

BP ___________________________

RESP ________________________

PULSE _______________________

HEALTH HISTORY