PATIENT'S MEDICAL INFORMATION

NAME: _____

(1) Are you currently under the care of a physician? _____Yes No
(2) Have you ever had a major operation? _____ Yes No
(3) Have you been in the hospital in the past 5 years? _____ Yes No
(4) Do you have an allergy to any medication, materials, or foods? _____ Yes No
If yes please list_____
(5) Are you currently taking any medication? _____ Yes No
If yes please list_____
(6) Approximate date of your last dental appointment_____
(7) Do you smoke? _____Yes No
If yes, how many packs per day_____

HAVE YOU EVER HAD?

Anemia_____ yes no
Asthma_____ yes no
Bleeding disorder_____ yes no
Cancer/malignancy_____ yes no
Congenital heart disease_____ yes no
Convulsions/Seizures/Epilepsy_____ yes no
Diabetes_____ yes no
Fainting/dizziness_____ yes no
Hay fever_____ yes no
Heart disease_____ yes no
Heart murmur_____ yes no
Hepatitis (liver disease)_____ yes no
High blood pressure_____ yes no
Joint Replacement of any kind_____ yes no
Kidney disease_____ yes no
Latex Allergy _____ yes no
Low blood pressure_____ yes no
Radiation treatments_____ yes no
Reaction to Novocaine or other anesthetic yes no
Rheumatic fever_____ yes no
Sickle cell anemia_____ yes no
Seizure disorder_____ yes no
Stroke_____ yes no
Taking multiple medications _____ yes no
Treatment for nervousness_____ yes no
Tuberculosis (TB)_____ yes no
Venereal disease (VD)_____ yes no

(8) Have you ever tested positive for or suspect that you may have acquired immune deficiency syndrome (AIDS)_____ yes no
(9) Women: Do you suspect that you may be pregnant? _____yes no
(10) Do you have any medical or dental condition not mentioned above which should be brought to our attention? _____yes no
If yes, please specify_____
(11) Skin reactions to nickel or non-gold jewelry such as earrings or watch bands? _____ yes no

Medical Doctor_____Address_____

Phone_____

Please
Sign_____Date_____