



MEDICAL HISTORY

Are you currently taking any prescription / over-the-counter drugs? YES NO

PLEASE LIST ON LINE BELOW

For Women: Are you taking birth control pills? YES NO

Are you pregnant? YES NO

If so, what week #: _____

Are you nursing? YES NO

Have you ever had any of the following diseases or medical problems? Please select all that apply.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Trauma/Injury |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Hospitalized |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures | Explain: _____ |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Shingles | _____ |

Have you experienced any serious conditions / problems not listed above? YES NO

If "Yes" please explain: _____

Are you allergic to any of the following? Please select all that apply.

- | | | | |
|----------------------------------|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Azithromycin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |

Please list any other drugs or items you are allergic to:

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of this staff responsible for any errors or omissions that I may have made in completion of this form. I understand that I am responsible for payment of services rendered and responsible for paying any co-payments and deductibles that my insurance does NOT cover.

Print Name: _____

Date: _____

Signature: _____

Reviewed by Dr. _____