MEDICAL HISTORY

Patient's Name _____ Date _____

Dentist's Name _____ Date of Last Dental Exam _____

Physician's Name _____ Date of Last Physical Exam _____

Allergies or reactions to any of the following:

Y__N__ Aspirin, Ibuprofen or Tylenol
Y__N__ Barbiturates
Y__N__ Codeine or other narcotics
Y__N__ Latex
Y__N__ Local anesthetics
Y__N__ Metals
Y__N__ Penicillin or other antibiotics
Y__N__ Plastic or vinyl
Y__N__ Sedatives
Y__N__ Sleeping pills
Y__N__ Sulfa drugs
Y__N__ Other _____

Medications:

Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Now or in the past, has the patient had:

Y__N__ Adenoids or tonsils removed
Y__N__ Arteriosclerosis (hardening of the arteries)
Y__N__ Asthma, hay fever, sinus trouble or hives
Y__N__ Autoimmune disorders or immune system problems
Y__N__ Bleeding or bruising easily
Y__N__ High or low blood pressure – please circle
Y__N__ Cancer, tumor, chemotherapy or radiation treatment
Y__N__ Chronic fatigue
Y__N__ Current pregnancy
Y__N__ Depression or other mental health disturbance
Y__N__ Diabetes
Y__N__ Dizziness
Y__N__ Epilepsy or other seizure disorder
Y__N__ Fibromyalgia
Y__N__ General anesthesia
Y__N__ Hearing impairment
Y__N__ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y__N__ Frequent coughs, colds or sore throats
Y__N__ Hemophilia
Y__N__ Hepatitis, AIDS or HIV positive
Y__N__ Injury to face, neck, mouth or teeth – please circle
Y__N__ Insomnia
Y__N__ Jaw joint surgery
Y__N__ Kidney or liver problems
Y__N__ Meniere's disease
Y__N__ Multiple sclerosis
Y__N__ Muscular dystrophy
Y__N__ Nighttime breathing problems (snoring or sleep apnea)
Y__N__ Nervousness
Y__N__ Neuralgia
Y__N__ Osteoarthritis (stiff or swollen joints)
Y__N__ Osteoporosis
Y__N__ Parkinson's disease
Y__N__ Prior orthodontic treatment
Y__N__ Psychiatric care
Y__N__ Rheumatic fever
Y__N__ Rheumatoid arthritis
Y__N__ Scarlet fever
Y__N__ Skin disorder
Y__N__ Speech difficulties
Y__N__ Stroke or heart attack
Y__N__ Tuberculosis
Y__N__ Wisdom teeth extraction
Y__N__ Birth defects or hereditary problems
Y__N__ Endocrine or thyroid problems
Y__N__ Stomach ulcer or hyperacidity
Y__N__ Polio, mononucleosis or pneumonia
Y__N__ Vision problems
Y__N__ Loss of weight recently, poor appetite
Y__N__ Eating disorder (anorexia or bulimia)
Y__N__ Chest pain, shortness of breath or swelling ankles
Y__N__ Frequent or severe headaches
Y__N__ Other condition

Emergency Contact _____ Relationship _____ Phone # _____

Patient/Parent Signature _____ Today's Date _____

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