Name: _____ , _____ _____ Social Security # ___ - ___ - ____
Last First Middle (no initials)

Date of Birth: ___/___/___ Age: _____ Spouse's Name (if married): _____
Yrs Mos

Address: _____ , _____ , _____ , _____
Street City State Zip

Phone: (___) _____ (___) _____ _____
Home Work E-Mail

Patient or Parent Employed by: _____ How Long? _____

Spouse Employed by: _____ How Long? _____

Name of Physician: _____ (___) _____ _____
Name Number Date of last visit

Name of Dentist: _____ (___) _____ _____
Name Number Date of last visit

Patient Referred by: _____ Reason for Visit: _____
Name

Medical History

Do you have, or have you ever had:

Yes	No		Yes	No		Yes	No	
		Heart Disease			Hepatitis (A, B, C)			Enlarged Lymph Glands
		Heart Attack or Stroke			Stomach Disorder/ulcers			Sinus Problems
		Heart Murmur			Unexplained Weight Loss			Sore or Hoarse Throat
		Heart Surgery			Endocrine Disorder			Eye problems
		Chest Pains (Angina)			Diabetes			Drug/Alcohol Abuse or Addiction
		Artificial Heart Valve			Thyroid Disease			Psychiatric Treatment
		Heart Pacemaker/Defibrillator			Bone Disorder			Cancer or Tumor
		Hardening of the Arteries			Kidney Disease			Radiation Therapy
		High Blood Pressure			Frequent Urination			Chemotherapy
		Rheumatic Fever			Constant thirst			Prostate Trouble
		Shortness of Breath			Anemia or Hemophilia			Had Orthodontic braces
		Swelling of the Ankles			Bruise Easily			Treated for Periodontal disease
		Tire Easily			Sickle Cell Disease			Sore teeth
		Lung Disease			Blood Transfusion			Sore or popping jaw joints
		Emphysema			Skin rashes or Hives			Do you fear dental treatment?
		Hay Fever or Asthma			HIV/AIDS/STD's			**WOMEN**
		Pneumonia			Arthritis			Pregnant now, or plan on becoming pregnant?
		Persistant Cough			Rheumatism			Currently taking any contraceptives?
		Tuberculosis			Pain in Joints			Have you entered menopause?
		Fainting or Dizziness			Artificial Joint(s)			Do you take estrogen?
		Epilepsy or Seizures			Take aspirin or blood thinner			
		Liver Disease/Jaundice			Facial Pain			

_____ _____
Signature Date

What is your present health? Good Fair Poor

Are you presently taking any medications or drugs? Specify (print): _____

Are you ALLERGIC to any medication, drugs, or substance? Specify: _____

Are you now or have you ever been under the care of a physician during the last 2 years? Specify: _____

Have you ever been hospitalized or had surgery? Specify: _____

Have you had your tonsils or adenoids removed? When? _____

Have you ever had a reaction to local anesthetic?

Have you ever had prolonged bleeding after injury or tooth extraction? Specify: _____

Do you smoke or use smokless tobacco? How long? How much? _____

Do you have or have you ever had any diseases, conditions, or problems not listed above? Specify: _____

BP _____