Check the box if you have or have had any of the following:

**Please check this box if none of the following applies to you ☐

	YES		YES
AIDS	☐	Heart Murmur	☐
Allergies (seasonal)	☐	Hepatitis __A __B	☐
Anemia	☐	High Blood Pressure	☐
Angina	☐	Joint Replacement	☐
Arthritis	☐	Kidney Disease	☐
Artificial Joints	☐	Leukemia	☐
Asthma	☐	Liver Disease	☐
Cancer (____________)	☐	Low Blood Pressure	☐
Cardiac Pacemaker	☐	Mental Disorder	☐
Diabetes (Type_____)	☐	Mitral Valve Prolapse	☐
Dizziness/Fainting	☐	Radiation Therapy	☐
Easily Winded	☐	Respiratory Problems	☐
Eczema	☐	Recent Weight Loss	☐
Emphysema	☐	Rheumatic Fever	☐
Epilepsy/Seizures	☐	Sexually Transmitted	☐
Excessive Bleeding	☐	Sinus Problems	☐
Frequently Tired	☐	Stomach Problems	☐
Glaucoma	☐	Stroke	☐
Head Injuries	☐	Swollen Ankles	☐
Heart Attack	☐	Thyroid Problems	☐
Heart Bypass	☐	Tuberculosis	☐
Heart Disease	☐	Ulcers	☐

Other:____

Are you allergic to or have you had any reactions to the following:

**Please check this box if none of the following applies to you ☐

	YES		YES
Novocaine Reaction:__________	☐	Iodine Reaction:__________	☐
Penicillin Reaction:__________	☐	Aspirin Reaction:__________	☐
Sulfa Reaction:__________	☐	Metal (nickel, mercury) Reaction:__________	☐
Barbiturates Reaction:__________	☐	Latex Reaction:__________	☐
Sedative Reaction:__________	☐	Other:__________ Reaction:__________	☐

Patient Medical History

General Physician:__________ City, State__________ Phone #__________

Specialist Physician:__________ City, State__________ Phone #__________

	YES	NO	
Are you currently under medical treatment?			Explain:
Have you been hospitalized for any surgical operation or illness in the last 5 years?			Explain:
Are you taking any medications including non-prescription medicine? (If you have a list we will copy it instead)			List:
Are you on a blood thinner?			Are you able to suspend med for dental treatment?
Do you use controlled substances?			Explain:
Women only:			
Are you pregnant?			How far along?
Are you nursing?			
Are you taking birth control?			

Patient Dental History

Previous Dentist:__________ City, State__________ Phone #__________

Last Exam/Cleaning:__________ Do we have your x-rays from this provider?__________