MEDICAL HISTORY

Patient Name: ___________________________ Date of Birth: _________________

YES	NO	
		1. Do you consider yourself to be in good health?
		2. Are you now or have you been under a physician's care within the past year?
		If yes, specify condition being treated:
		3. **Do you take any medications**, including birth control pills?
		Please specify name and purpose of medication:
		a. b.
		c. d.
		4. **Do you require antibiotic pre-medication** for a heart condition, artificial valve or artificial joint?
		5. Have you ever been told that you have a heart murmur?
		6. Do you have or have you ever had any heart or blood problems?
		7. Have you ever been diagnosed with high blood pressure?
		8. Have you ever been diagnosed as being HIV positive or having AIDS?
		9 . Have you ever had: Hepatitis Y / N
		Rheumatic fever Y / N Asthma Y / N Liver disease Y / N
		Diabetes Y / N Arthritis Y / N Tuberculosis Y / N Type: I / II
		Heart attack Y / N Kidney disease Y / N Immune disorder Y / N
		Osteoporosis Y / N Artificial Joints Y / N Other:
		10. Have you ever had an unusual reaction or are you allergic to any of the following drugs:
		Penicillin Y / N Aspirin Y / N Acetaminophen Y / N Ibuprofen Y / N
		Codeine Y / N Barbiturates Y / N Sulfa Drugs Y / N Other:
		11. Have you ever had any severe medical reaction to dental treatment or local anesthetics?
		12. **Are you allergic to anything? Also, antibiotics or medications?** If yes, please list:
		13. Have you ever had a nervous breakdown or undergone psychiatric treatment?
		14. Have you ever been treated for a drug or alcohol abuse problem?
		15. Are you pregnant?
		16. When were you last seen by a dentist? For what reason:
		17 . Do you use chewing tobacco or smoke cigarettes?
		18. Have you ever taken Phen-Fen or similar appetite suppressants?
		If yes, have you seen a physician or cardiologist for cardiac evaluation?

History last updated:________ ________ __________ __________ __________ _________ __________ _________

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature:____ Date: ___________________________

(Patient, legal guardian or authorized agent of patient)