

Patient's Name _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? () Yes () No

If yes, give approx. dates _____

(Women)

Are you pregnant? ()Y ()N Nursing? ()Y () N Taking birth control? () Y () N

Check () if you have had any of the following:

- | | |
|-----------------------------|--------------------------------|
| () Aids | () Hepatitis |
| () Anemia | () High Blood Pressure |
| () Arthritis | () HIV Positive |
| () Artificial Heart Valves | () Jaw Pain |
| () Artificial Joints | () Kidney Disease |
| () Asthma | () Liver Disease |
| () Back Problems | () Mitral Valve Prolapse |
| () Blood Disease | () Nervous Problems |
| () Cancer | () Pacemaker |
| () Chemical Dependency | () Psychiatric Care |
| () Chemotherapy | () Radiation Treatment |
| () Circulatory Problems | () Respiratory Disease |
| () Cortisone Treatments | () Rheumatic Fever |
| () Cough up Blood | () Scarlet Fever |
| () Diabetes | () Shortness of Breath |
| () Epilepsy | () Skin Rash |
| () Fainting | () Stroke |
| () Glaucoma | () Swelling of Feet or Ankles |
| () Headaches | () Thyroid Problems |
| () Heart Murmur | () Tobacco Habit |
| () Heart Problems | () Tonsillitis |
| describe _____ | () Tuberculosis |
| () Hemophilia | () Ulcer |
| | () Venereal Disease |

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____
