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Medical History

Date: ___/___/___

Name _____ Address _____

E-mail: _____

City _____ State ___ Zip _____ Telephone:(Home) _____ (Bus) _____

Date of Birth ____/____/____ Sex ____ Occupation _____ Cell Phone _____

Social Security No. ____-____-____ Single Married Widowed Spouse's Name _____

Do you have dental insurance? Yes___ No ___ Name of Carrier: _____

Name of Insured _____

Insured's Employer _____ Referred by _____

Spouse's Birthdate _____/_____/___ Spouse SS No. _____-_____-_____ General Dentist _____
(if insured)

Emergency Contact: _____ Phone: _____ Relationship : _____

In the following questions, circle yes or no, whichever applies. *Your answers are for our records only and will be kept confidential.*

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician is _____
   _____
6. Have you had any serious illness or operation? ..... Yes No
   If so, what was the operation or illness? _____
7. Have you ever been hospitalized or had a serious illness within the past five(5) years? ..... Yes No
   If so, what was the problem? _____
8. Have you ever had an orthopedic joint (hip, knee, elbow, finger) replacement? ..... Yes No
9. Has a physician or dentist ever recommended that you take antibiotics prior /before your dental treatment? ..... Yes No
   If yes, what antibiotic and dose? _____
10. Do you have or have you ever had any of the following diseases or problems? *Please Circle*

Diabetes Type I (Insulin Dependent)	Yes	No	Diabetes Type II	Yes	No
Cardiovascular Disease	Yes	No	Congenital Heart Defect	Yes	No
Angina	Yes	No	Heart Murmur	Yes	No
Arteriosclerosis	Yes	No	High Blood Pressure	Yes	No
Artificial Heart Valves	Yes	No	M. V. P.	Yes	No
Coronary Artery Disease	Yes	No	Rheumatic Fever	Yes	No
Stroke	Yes	No	Neurological Disorders	Yes	No
Kidney Problems	Yes	No	Thyroid Problems	Yes	No
Cardiac Pacemaker	Yes	No	Low Blood Pressure	Yes	No
Asthma or Hayfever	Yes	No	Anemia	Yes	No
Blood Transfusion	Yes	No	Hemophilia	Yes	No
Fainting spells or seizures	Yes	No	Epilepsy	Yes	No
Hepatitis, A, B, or C	Yes	No	Aids or HIV infection	Yes	No
Liver disorders	Yes	No	Osteoporosis	Yes	No
Arthritis, rheumatoid arthritis	Yes	No	Sexually Transmitted Diseases	Yes	No
Ulcers	Yes	No	Eating disorders	Yes	No
Tuberculosis	Yes	No	Cancer	Yes	No
Mental Health Disorders	Yes	No	Severe Headaches/Migraines	Yes	No
Bladder Pacemaker	Yes	No	Do you use tobacco	Yes	No

PLEASE TURN OVER