Circle Yes or No

MEDICAL HISTORY

Yes No 1. Are you in poor health?
Yes No 2. Have you been examined by a physician within the last year?
Yes No 3. Have you been a patient in a hospital in the last 3 years?
Yes No 4. Have there been changes in your health this year?
Yes No 5. Have you ever been seriously ill?
Yes No 6. Have you been treated for a growth or tumor?
Yes No 7. Do you often feel exhausted or fatigued?
Yes No 8. Have you ever had painful or swollen joints?
Yes No 9. Do you have any chest pain on exertion?
Yes No 10. Do you bruise easily?
Yes No 11. Do you bleed a long time when you are cut?
Yes No 12. Do you have a pacemaker?
Yes No 13. Do you ever have hives or skin rashes?
Yes No 14. Have you ever had an unusual reaction to a Dental anesthetic, Penicillin, Barbiturates, Aspirin, Codeine, Sulfa, Other?_____
Yes No 15. Are you prone to motion sickness?
Yes No 16. (Child) Are immunizations current for diptheria, pertussis, tetanus, measles, mumps, polio?
Yes No 17. (Women) Are you pregnant?
Yes No 18. Have you ever taken Phen Phen or been prescribed dietary prescription drugs?
Yes No 19. Have you ever had any of the following:

- ☐ Loss of Weight
- ☐ Dysentery
- ☐ Open Sores
- ☐ Loss of Appetite
- ☐ Organ Transplants
- ☐ Psychiatric Treatment
- ☐ Swollen Glands
- ☐ Swelling of Ankles
- ☐ Spontaneous Bleeding
- ☐ Aids
- ☐ Herpes
- ☐ Blood Thinners
- ☐ Aids Test Performed
- ☐ Aspirin Therapy
- ☐ Ulcer
- ☐ Night Sweats
- ☐ Latex Allergy
- ☐ Toxoplasmosis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Tuberculosis
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Arthritis
- ☐ Heart Trouble
- ☐ Stroke
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ HIV Positive
- ☐ Pace Maker
- ☐ Glaucoma
- ☐ Tricyclic Antidepressants
- ☐ Chills
- ☐ Fever Unknown Origin
- ☐ Osteoperosis
- ☐ Mitral Valve Prolapse (MVP)
- ☐ Venereal Disease
- ☐ Drug Addiction
- ☐ Heart Murmur
- ☐ Frequent Headaches
- ☐ Fainting Spells
- ☐ Alcoholism
- ☐ Asthma
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Epilepsy
- ☐ MAO Inhibitors
- ☐ Prosthetic Joint
- ☐ Anorexia
- ☐ Bulimia
- ☐ Bloody Sputum
- ☐ Hemoptysis

DENTAL HISTORY

Yes No 1. Have you been having any specific problem?
Yes No 2. Has fear of discomfort kept you from regular visits?
Yes No 3. Do your gums bleed?
Yes No 4. Are you troubled with bad breath?
Yes No 5. Do you have sensitive teeth?
Yes No 6. Do you have difficulty in chewing your food?
Yes No 7. Have you noticed any loosening of your teeth
Yes No 8. Do your jaws "pop" or "lock" when opening your mouth
Yes No 9. Do you or have you had sinus trouble
Yes No 10. Have you ever had:
☐ Injury to your face, jaws or teeth? ☐ Oral surgery?
☐ Orthodontic treatment? ☐ Periodontal (gum) surgery?
Yes No 11. Do you have any disease, condition, or problem not listed above that I should know about?
12. How do you feel about the possibility of losing your teeth?

_____

Yes No 13. Have you taken any medications within the last year?

CURRENT MEDICATIONS	REASON

CERTIFICATION: I certify that the answers to the health questions are correct to the best of my knowledge.

AUTHORIZED SIGNATURE _____

DATE _____

CERTIFICATION OF CURRENT HEALTH CONDITIONS: I certify that I am in good health and there has been no change in my health except as noted below.

DATE	AUTHORIZED SIGNATURE	CHANGES

MEDICAL SUMMARY: _____

_____

_____MEDICAL HISTORY