CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Date of Last Physical Exam___________________Physician's name_____________________

Are you now or have you recently been under a physician's care? ____ Yes ____ No

Reason:____

Have you ever been a patient in a hospital or had a serious illness? ____Yes ____No

Explain:____

Please answer the following:

Do you smoke?	Y	N
Do you use any tobacco products?	Y	N

Women please answer the following:

Are you taking Birth control Pills?	Y	N
Are your pregnant?	Y	N
Are you nursing?	Y	N

Conditions:

ABNORMAL BLEEDING	Y	N
ALCOHOL ABUSE	Y	N
ANEMIA	Y	N
ARTHRITIS	Y	N
ARTIFICIAL HEART VALVE	Y	N
ASTHMA	Y	N
BLOOD TRANFUSION	Y	N
CANCER/CHEMOTHERAPY	Y	N
COLITIS	Y	N
CONG. HEART DEFECT	Y	N
COSMETIC SURGERY	Y	N
DIABETES	Y	N
DIFFICULTY BREATHING	Y	N
DRUG ABUSE	Y	N
EMPHYSEMA	Y	N
FAINTING SPELLS	Y	N
FEVER BLISTER	Y	N
FREQUENT HEADACHES	Y	N
GLAUCOMA	Y	N
HAY FEVER	Y	N
HEART SURGERY	Y	N
HEMOPHILIA	Y	N
HIGH BLOOD PRESSURE	Y	N
HIV / AIDS	Y	N
KIDNEY PROBLEMS	Y	N
LIVER DISEASE	Y	N
LOW BLOOD PRESSURE	Y	N
MITRAL VALVE PROLAPSE	Y	N
PACE MAKER	Y	N
PSYCHIATRIC PROBLEMS	Y	N
RADIATION THERAPY	Y	N
RHEUMATIC FEVER	Y	N
SHINGLES	Y	N
SICKLE CELL DISEASE	Y	N
SINUS PROBLEMS	Y	N
STROKE	Y	N
THRYROID PROBLEMS	Y	N
TUBERCULOSIS	Y	N
VENEREAL DISEASE	Y	N
YELLOW JAUNDICE	Y	N
ANGINA/CHEST PAINS	Y	N
EPILEPSY / SEIZURES	Y	N
EPILEPSY/CONVULSIONS	Y	N
HEART MURMER	Y	N
JOINT REPLACEMENT	Y	N
IMPLANTS (DENTAL)	Y	N
BLOOD THINNERS	Y	N
HEART ATTACK/DISEASE	Y	N
HEPATITIS A, B, C	Y	N

ALLERGIES:

ASPIRIN	Y	N
CODEINE	Y	N
DENTAL ANESTHETICS	Y	N
ERYTHROMYCIN	Y	N
JEWELRY	Y	N
LATEX	Y	N
METALS	Y	N
PENICILLIN	Y	N
TETRACYCLINE	Y	N
OTHER _______________	Y	N

Please list all Medications: