

PATIENT'S NAME _____
 Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

1. Family Physician's Name _____
 Address _____
2. When was your last complete physical exam? _____
3. Are you taking any medications, vitamins or supplements?.....YES NO
 If so list _____
4. Are you allergic to any medications or substances?.....YES NO
 If so list _____
5. Do you have any other allergies?.....YES NO
 If so list _____
6. Do you have any sensitivities to penicillin, antibiotics, anesthetics
 or other medications?.....YES NO
 If so list _____
7. Are you sensitive to any metals or latex?.....YES NO
8. Are you pregnant or suspect you may be.....YES NO
 If so how many weeks? _____
9. What type of birth control do you use? Please list _____
10. Have you ever been treated for or
 been told you have heart disease?.....YES NO
 If so list _____
11. Do you have a pacemaker or an artificial heart valve implant?.....YES NO
 If so list _____
12. Do you have high or low blood pressure?.....YES NO
 If so which and list medications _____
13. Have you ever had a serious illness or major surgery?.....YES NO
 If so list date and type _____
14. Have you ever had radiation or chemotherapy treatment?.....YES NO
 If so list date and type _____
15. Do you have arthritis?.....YES NO
 If so list type and medications _____
16. Do you have any artificial joints / prosthesis?.....YES NO
 If so list date and type _____
17. Do you have any blood disorders, such as anemia, leukemia, etc?.....YES NO
 If so list _____
18. Do you have any stomach problems?.....YES NO
 If so list _____
19. Do you have any kidney problems?.....YES NO
 If so list _____
20. Do you have any liver problems?.....YES NO
 If so list _____
21. Are you diabetic?.....YES NO
 If so list type _____
22. Do you have asthma?..... YES NO
 If so list medications _____
23. Do you have epilepsy or seizure disorders?..... YES NO
 If so list type and medications _____
24. Do you have or have had a sexually transmitted disease?.....YES NO
 If so list _____
25. Have you tested HIV positive?.....YES NO
 If so when _____
26. Do you have any infectious diseases?.....YES NO
 If so list _____
27. Have you had or tested positive for hepatitis?.....YES NO
 If so list type and when _____
28. Do you or have you had T.B.?.....YES NO
29. Do you smoke tobacco?....YES NO How much? _____ For how long? _____
30. Do you chew tobacco?....YES NO List type _____ How much? _____ For how long? _____
31. Do you consume alcoholic beverages?.....YES NO
 If so how much? Daily _____ Weekly _____
32. Do you use controlled substances?.....YES NO
 If so list type and frequency _____
33. Have you had psychiatric treatment?.....YES NO
 If so list type and medications _____
34. Do you take medications for osteoporosis or osteopenia?.....YES NO
 If so list _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ DATE _____
 DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MEDICAL HISTORY

MED. ALERT