MEDICAL HISTORY

1. When was your last Medical physical exam? _____

2. Any recent change in your health? YES / NO Explain: _____

3. Are you under the care of a Medical physician? YES / NO Explain: _____

4. Have you been hospitalized or experienced a serious illness within the last 5 years? YES / NO

If YES, explain: _____

5. Last Dental Visit: _____

Please check which applies:

___ Diabetes

___ Tuberculosis

___ Kidney Problems / Dialysis

___ Arthritis / Rheumatism

___ High Cholesterol

___ Radiation / Chemo Therapy

___ Epilepsy / Dizziness / Fainting spells

___ AIDS / HIV / A.R.C

___ Rheumatic Fever

___ Anxiety / Depression

___ Blood Thinner

___ Osteoporosis / Bone Condition

___ Sleep Apnea / Sinus Problems

___ Thyroid Condition

___ Heart Condition: Explain:_____

___ Venereal Disease / STD

___ Pulmonary Disease / COPD/ Respiratory Condition

___ Asthma / Hay Fever / Allergies

___ High or Low Blood Pressure

___ Cancer: Explain: _____

___ Blood Disorders / Abnormal bleeding / Anemia

___ Hepatitis (A ,B ,C ,D) / Jaundice / Liver Condition

___ Auto Immune Disease: Explain: _____

___ Acid Reflux / G.E.R.D / Stomach condition

___ Heart Surgery Type:_____

___ Pacemaker / Defibrillator

___ Pregnant: How many months: _____

___ Taking Birth control

___ Joint / Organ / Body part Replaced with Artificial Parts?

If YES, explain: _____

6. Do you have any Disease, Condition or Problem that was not listed above? :

Explain: _____

7. List current Medication you are taking:

_____

8. Are you ALLERGIC to any drugs or medications (Aspirin, Penicillin, Codeine, or other)? YES / NO

List: _____

9. Do you experience pain or clicking in your jaw, ear or facial muscles upon opening your mouth? YES / NO

10. Does your gums bleed? YES / NO

11. Do you grind or clench your teeth: YES / NO

Patient / Guardian Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____