Medical Information

	YES	NO
(For women only)		
1.Are you pregnant?..	______	_____
If yes, in what month?________		
2.Are you taking birth control pills?...	______	_____
1.Are you presently under the care of a physician?......................	______	_____
If so, for what?____________________________________		
2.Have you ever been hospitalized?...	______	_____
If so, for what?____________________________________		
3.Are you presently taking any medications?..............................	______	_____
If so, please list____________________________________		
4.Have you ever had a blood transfusion?...................................	______	_____
5.Indicate which of the following you have had or have at the present:		
A. Heart Disease?.......................................	______	_____
B. Chest pain or angina pectoris?................	______	_____
C. Heart attack?..	______	_____
D. Mitral valve prolapsed?..........................	______	_____
E. Heart defect from birth?..........................	______	_____
F. Heart murmur?..	______	_____
G. Rheumatic fever or heart disease?...........	______	_____
H. High blood pressure?.............................	______	_____
I. Stroke?..	______	_____
J. Fainting spells, convulsion or epilepsy?...	______	_____
K. Treated for nervous or mental disorder?	______	_____
L. Chronic headache, backache or neck pain?	______	_____
M. Lung disease?.......................................	______	_____
N. Asthma?..	______	_____
O. Tuberculosis?..	______	_____
P. Liver disease?..	______	_____
Q. Drug addiction?....................................	______	_____
R. Hepatitis?..	______	_____
S. Jaundice, Cirrhosis?...............................	______	_____
T. Kidney disease?.....................................	______	_____
U. Kidney dialysis?....................................	______	_____
V. Diabetes?...	______	_____
X. Prolonged bleeding?...............................	______	_____
Y. Anemia?..	______	_____
Z. Syphilis, Gonorrhea, Herpes or other venereal disease?	______	_____

Medical Information "continued"

	YES	NO
AA. Joint surgery or prosthetic replacement?...............................	______	_____
AB. HIV positive or AIDS?..	______	_____
AC. Cancer, tumor or radiation therapy?.....................................	______	_____
AD. Allergy to penicillin, antibiotics, codeine, aspirin or any other medication?	______	_____
AE. Allergy to novocaine or xylocaine?.......................................	______	_____
AF. Any other allergy?..	______	_____
If so, please list____		
AG. Do you have any reason to believe that you are at risk for any infectious diseases such as Hepatitis or AIDS?..	______	_____
AH. Are a smoker?..	______	_____
AI. Have you taken any appetite suppressants in the last two years including Fen-Phen or dexfenfluameine or fenfluameine?..................	______	_____
AJ. Have you been under the care of a medical doctor during the past two years since taking any of the appetite suppressants named above?.........	______	_____
Physician's name________________________Phone#___________________________		
Address____		
AK. Do you have or have had any disease, condition or problem not listed?	______	_____
If so, please list____		

Name of your previous Dentist?____

Address____

________________________________Phone #________________________

Date of last cleaning and check up?_________________X-rays?___________________

Are you happy with your smile?_______________

Is there anything about your smile you would like to change?_____________________________

We thank you for selecting our dental office for you and your family, who should we thank for referring you to us?________________________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all of the questions truthfully and to the best of my knowledge.

Signature____Date_____________

(Patient, parent or guardian)

Reviewing Dr. Signature__________________________________Date_____________