Medical History

Last name: _____ First:_____ Birth date:_____

Who should we contact in an emergency? _____ Phone: _____
Are you currently under treatment or therapy? _____ For what? _____
_____
Physician's name: _____ Phone: _____
Medications you are currently taking, including herbal supplements & over-the-counter drugs: _____
_____

Do you have or have you had:	No	Yes	Date	Comments
Heart trouble				
High blood pressure				
Low blood pressure				
Heart implant (valve, stent, pacemaker)				
Joint replacement				
Lung disease				
Tuberculosis				
Emphysema				
Asthma				
Seasonal allergies				
Seizures or Epilepsy				
HIV or AIDS other STD				
Liver disease				
Hepatitis (type)				
Major surgery (type)				
Blood transfusion				
Blood disorder (anemia, leukemia)				
Bleeding problems				
Diabetes				
Glaucoma				
Arthritis (type)				
Cancer (type)				
Chemotherapy				
Radiation therapy				
Thyroid disorder				
Kidney disorder				
Stomach ulcers				
Mouth ulcers				
Osteoporosis				
Drug or alcohol abuse				
Emotional or Psychological Disorder				
Any other medical conditions				

Initial _____

Have you ever had a reaction to:	No	Yes	Describe
Penicillin			
Erythromycin			
Tetracycline			
Codeine			
Aspirin			
Acetaminophen			
Ibuprofen			
Sulfa			
Metals			
Latex			
Phisohex			
Acrylic			
Other			

Do you use:	No	Yes	Type	Quantity
Tobacco				
Alcohol				
Drugs				

Are You:	No	Yes	
Hearing impaired:			
Visually impaired:			
Other disabilities:			

Have you been diagnosed or do you suspect that you have a sleeping disorder? _____

Are you aware that there is a detrimental relationship between gum disease and systemic diseases such as Diabetes and Heart disease? _____

Women:	No	Yes	
Are you pregnant?			_____ Due Date: _____
Are you taking hormone replacement?			Type _____
Are you taking birth control pills?			Type _____

Patient's signature: _____ Date: _____

Doctor's notes:
B.P._____ASA_____
_____
_____

For Medical Update Use Only:

Patient's Signature _____ Date: _____

Patient's Signature _____ Date: _____

Patient's Signature_____ Date: _____