MEDICAL HISTORY

(Patient's) First Name _____ **Last Name** _____ **Date of Birth**_____

Are you under the care of a Medical Doctor? .....Yes No

Are you taking any medications? .....Yes No

If Yes, Please List: _____

_____

Are you allergic to any medications? .....Yes No

If Yes, Please List: _____

Are you allergic to anything else? .....Yes No

If Yes, Please List: _____

Are you pregnant or suspect you may be? ....Yes No

Do you have any heart issues? .....Yes No If Yes, What? _____

Have you had a heart attack or stroke in the past 6 months? .....Yes No

Do you have Angina? .....Yes No If Yes, circle one STABLE UNSTABLE

Do you have high blood pressure or low blood pressure? .....Yes No If Yes, circle one HIGH LOW

Are you undergoing chemotherapy or radiation therapy? .....Yes No

Do you have any blood disorders or bleeding problems? .....Yes No

Do you have any problems with any of the organs in your body? .....Yes No If Yes, Which? _____

Are you HIV positive or do you have AIDS? .....Yes No

Are you TB positive or do you have TB? .....Yes No

Do you have Hepatitis? .....Yes No If Yes, Which? _____

Are you diabetic? .....Yes No If Yes, Type? _____

Do you smoke, chew, or use other form of tobacco? .....Yes No Packs Per Day? _____

Do you have asthma, or other respiratory illnesses? .....Yes No

Do you use illicit drugs or habitually use controlled substances? .....Yes No

Are you under psychiatric care? .....Yes No

Did you ever have a seizure? .....Yes No

Do you have an inflammatory disease or autoimmune disorders? .....Yes No

If you have any medical conditions or diseases not covered on this form, LIST THEM: _____

I certify that the above information is complete and accurate (must be date signed)

Patient's Signature _____ **Date** _____

Dentist's Signature _____ **Date** _____