MEDICAL HISTORY

MEDICATIONS

List any medications you are taking
_____
_____

ALLERGIES

_____ Penicillin ____ Codeine
_____ Sulfa ____ Anesthetics
_____ Other ____ Aspirin

CHECK if you have or have ever had any of the following:

____AIDS
____ Anemia
____ Antibiotic coverage before dental work
____ Arthritis, Rheumatism
____ Artificial Heart Valves
____ Artificial joints
____ Asthma
____ Blood Disease
____ Cancer
____ Chemical dependency
____ Chemotherapy
____ Circulatory problems
____ Diabetes
____ Epilepsy
____ Fainting
____ Headaches
____ Heart murmur
____ Heart problems
____ High blood pressure
____ Hemophilia
____ Hepatitis: When _____type __
____ HIV positive
____ Kidney Disease
____ Liver Disease
____ Mitral Valve Prolapse
____ Pacemaker
____ Radiation Treatment
____ Respiratory Disease
____ Rheumatic fever
____ Stroke
____ Thyroid Problem
____ Tobacco habit..
____ How Much?
____ Tuberculosis
____ Tumor history
____ Ulcer
____ Venereal disease
____ Other_____
_____

Have you had any **serious** illness or operations?_____
_____

(**Women**) Are you pregnant? _____ Nursing? _____

Physician's name _____ Phone _____Last visit _____

Pharmacy _____ Location _____ Phone _____

In case of **emergency**, whom should we notify? _____
Phone _____ Relationship _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____