MEDICAL/DENTAL HISTORY

Name of your Physician:_____ **Date of Last Visit**:_____

Please circle any of the following that you have or have had:

Heart Trouble	Cancer	Asthma
Rheumatic Fever	Radiation Treatment	Hives or Skin Rash
Mitral Valve Prolapse	Arthritis	Depression\Anxiety
Heart Murmur	Osteoporosis	Substance Abuse
Angina	Joint Replacement Surgery	Venereal Diseases
Stroke	Liver Disease-jaundice/hepatitis	Herpes Oral (cold sores)
High Blood Pressure	Kidney Disease	Herpes Genital
Diabetes	Thyroid Condition	HIV Positive
Fainting Spells/Seizures	Ulcers	AIDS
Clenching\Grinding TMJ Disorder	Sinus Trouble	Tuberculosis
Bleeding Disorder	Environmental Allergies	Major Surgery

Please list any medications you are allergic or have reacted adversely to:

Name	Reaction	Name	Reaction

Please name all current medications, dosage, & reason for taking them:

Name	Dose	Reason	Name	Dose	Reason

Do you smoke?_____
Women: Are you pregnant?_____
Do you have any other disease, condition, or problem not listed above?_____ **Please explain**_____

Dental History

1. Have you had any trouble associated with previous dental treatment (dizziness, fainting or reaction to novocaine)? Yes No
2. Do you have any lumps or sores in your mouth now? Yes No
3. Are you Allergic to Latex? Yes No Reaction _____

To the best of my knowledge, the above information is correct and complete.

_____ _____ _____ _____
Patient's Signature **Date** **Reviewed** **Date**

_____ _____ _____ _____
Patient's Signature **Date** **Reviewed** **Date**