

Medical History:

Name: _____

Have you had any of the following medical conditions? Please check all that apply:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Mental/Nervous Disorder | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |

Do you require pre-medication: YES NO

Have you been admitted to a hospital or needed emergency care during the past 2 years?

YES NO Clarify: _____

Are you now under the care of a physician due to any medical emergencies?

YES NO Physician Information: _____

Are you taking any of the following medications?

- | | | | | |
|--|---|--|-------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Steroids | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Bisphosphonates | <input type="checkbox"/> Insulin | <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Stimulants | |

Please list ALL medications:

Are you allergic any of the following medications?

Aspirin Codeine Latex Penicillin/Amoxicillin Sulfa Others? Please list: _____

FOR WOMEN:

Are you Pregnant? YES NO Are you taking Birth Control? YES NO

Due Date: _____

Please list any Dental Health changes:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment.

Signature: _____ Date: _____