Medical History

Do you have or have you had any of the following? Please Circle Answer

Heart Disease/Attack/Surgery	Y N	Tumors/ Growths	Y N
Angina	Y N	Cancer	Y N
High Blood Pressure	Y N	Radiation/ Chemotherapy	Y N
Artificial Heart Valves	Y N	Athritis	Y N
Heart Pacemaker	Y N	Glaucoma	Y N
Artificial Joints	Y N	H IV / AIDS	Y N
Pre-medicate for Dental Trtmt?	Y N	Hepatitis A, B, C	Y N
Stroke	Y N	Liver Disease	Y N
Kidney Problems	Y N	Alcoholism	Y N
C.O.P.D.	Y N	Drug Addiction	Y N
Tuberculosis (T B)	Y N	Hemophilia	Y N
Asthma	Y N	Cold Sores	Y N
Diabetes	Y N	Epilepsy or seizures	Y N
Sickle Cell Disease	Y N	Thyroid Disease	Y N

Is there any disease , condition or problem you have that we should be aware of? Is there any activity your doctor said you could not or should not do? Explain _____

Reason for this visit? _____ Last Dental APPT? _____

Does dental treatment make you nervous? Please circle No Slightly Moderately Extremely

Treated for Periodontal Disease (Gum Disease, Pyorrhea, Trench Mouth)? Y N

Please **Underline** if Applicable : Bleeding/sore gums, Bad Breath/ Taste, Burning tongue/Lips, Blisters on Lips/Mouth, Swelling/ Lumps in Mouth,Biting Lips/ Cheeks, Loose Teeth, Sensitive to Heat/ Cold/Sweets/ Biting, Packing Food Between Teeth, Clenching/ Grinding, Smoker

I have completed this for to the best of my ability. I am the patient or the patients authorized agent/guardian and am qualified to answer these questions.

Signature of Patient (or Parent or Guardian if patient is a minor) _____ Date _____

Dentists Signature _____ Date