

MEDICAL HISTORY

Please circle yes or no for each of the following that apply to you:

- | | |
|--------------------------|---------------------------|
| Y N - Allergy to Latex | Y N - Glaucoma |
| Y N - Anemia | Y N - Heart Disease |
| Y N - Artificial Joints | Y N - Heart Murmur |
| Y N - Asthma | Y N - Hepatitis |
| Y N - Blood Disease | Y N - High Blood Pressure |
| Y N - Cancer | Y N - HIV/AIDS |
| Y N - Currently Pregnant | Y N - Pacemaker |
| Y N - Diabetes | Y N - Radiation Treatment |
| Y N - Dizziness | Y N - Stroke |
| Y N - Epilepsy/ Seizures | Y N - Sinus Problems |
| Y N - Excessive Bleeding | Y N - Tuberculosis |
| Y N - Fainting | Y N - Venereal Disease |

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED?

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

DO YOU HAVE ANY CONDITION THAT REQUIRES YOU TO BE PREMEDICATED WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? YES OR NO _____

EMERGENCY CONTACT PERSON: _____

TELEPHONE: _____

PATIENT/GUARDIAN SIGNATURE: _____