MEDICAL HISTORY:

Indicate by circling Yes or No to any of the conditions below for which you are being treated or have been treated for in the past:

Y/N Recent Heart attack	Y/N Sinus problems
Y/N Heart surgery	Y/N Diabetes
Y/N Heart rhythm problems	Y/N Thyroid disease
Y/N Artificial heart valves	Y/N Kidney disease
Y/N Angina	Y/N Organ transplant
Y/N Hypertension (high blood pressure)	Y/N Gastric ulcer
Y/N Cardiac pacemaker	Y/N Acid reflux disease
Y/N Congenital heart disease	Y/N Rheumatic fever
Y/N Stroke	Y/N Arthritis
Y/N Epilepsy	Y/N Psychiatric Illness
Y/N Seizures	Y/N Substance abuse
Y/N Migraines	Y/N Sexually Transmitted Disease
Y/N Syncope (fainting spells)	Y/N Artificial joint
Y/N Cancer. If yes, what type and date:	Y/N Radiation treatments
Y/N Blood disorders/ easy bruising	Y/N Tuberculosis
Y/N Liver disease	
Y/N HIV/AIDS	*Women Only:*
Y/N Lung disease	Y/N Currently pregnant
Y/N Asthma	Y/N Nursing
Y/N Emphysema	

Have you had any serious illness, disease, or condition not listed above? Y/N
If yes, please explain: _____

Have you been hospitalized or under the care of a physician within the last 2 years? Y/N
If yes, please explain: _____

Have there been any change in your general health within the past 2 years? Y/N
If yes, please explain_____

List any medications you are currently taking (including weight loss products, herbal/vitamin supplements, birth control medications, etc.): _____

_____

Do you have any drug allergies or have you had an adverse reaction to any medications you have taken? Y/N
If yes, please explain:_____

Do you smoke, chew, and/or use snuff or any other form of tobacco? Y/N How much? _____
Do you drink alcohol? Y/N How much? _____

The above information is accurate and complete to the best of my knowledge and is only for use of my treatment, billing and processing of insurance for benefits for which I am entitled. 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 of person completing form: _____ Date:_____