Since dental disease is produced by a combination of many complex elements, it is important to understand and resolve every possible contributing factor. Though some of the following questions may seem to be unrelated to your current condition, they are all consistent with the proper management or your oral health, and will be treated confidentially.

Name: _____ DOB: _____ Weight: _____ Height: _____

Medical Doctor: Name _____ Telephone # _____

Address _____

HAVE YOU EVER HAD OR HAVE YOU NOW: *(Please check at the RIGHT of each item)*

(Check each item)	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or Dizziness				Bruise or bleed easily				Kidney problems			
Nervousness				Heart problems or Angina				Venereal disease			
Stroke				High Blood Pressure				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold sores (Herpes)				Heart murmur				AIDS/HTLV-III positive			
Persistent cough				Mitral valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
Tuberculosis/PPD positive				Heart attack/failure				Artificial joint(s)			
Asthma				Artificial heart valve(s)				Hives			
Hay fever				Pacemaker				Steroid medications(s)			
Sinus problems				Blood transfusion(s)				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
Leukemia				Hepatitis-type:				Cancer/radiation therapy			
Chest pain				Shortness of breath				Swollen ankles			

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS: *(Please check to RIGHT of each item)*

Antibiotics				Drugs for heart trouble				Aspirin			
Medicine for blood pressure				Antihistamines				Sulfa Medications			
Digitalis, nitroglycerine				Insulin				Tranquilizers			
Anti-coagulants(blood thinner)				Cortisone (Steroids)				Other			

ARE YOU ALLERGIC OR HAVE YOU HAD AN UNUSUAL REACTION TO: *(Please check to RIGHT of each item)*

Novacaine, Lidocaine				Codiene, Demerol				Percocet, Percodan			
Barbiturates, sleeping pills				Iron				Aspirin			
Sulfa Medication				Antibiotics (penicillin)				Other			

1. HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD?			
2. Have you ever been hospitalized or had a major operation?			
3. FEMALES: Are you taking birth control pills (BCP's)			
Are you or might you be pregnant? (Estimated delivery _____)			
4. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE?			
IF YES, PLEASE DESCRIBE: _____			

I understand the need for these questions to be answered truthfully. All questions have been answered truthfully, and in my own hand. I understand that if any change occurs in my health I am to report it to the dental office.

SIGNED: _____ DATE: _____

SUMMARY OF PERTINENT FINDINGS / RECOMMENDED TREATMENT MODIFICATIONS: *(Dentist's use only)*

Reviewed by Doctor _____ Date _____ BP _____

DATE	CHANGES IN STATUS	CURRENT Rx	DR.