MEDICAL HISTORY

Your Physician _____ Type _____ How Long _____

Office Address _____ Zip _____ Phone _____

DO YOU HAVE OR HAVE YOU EVER HAD: (circle)

1. Hospitalization for illness or surgery..... Yes / No
2. An allergic reaction..... Yes / No
3. Any reaction to:
   a. aspirin..... Yes / No
   b. penicillin..... Yes / No
   c. erythromycin..... Yes / No
   d. tetracycline..... Yes / No
   e. codeine..... Yes / No
   f. sedatives or sleeping pills (barbiturates)..... Yes / No
   g. dental anesthetic..... Yes / No
   h. any other medication..... Yes / No
   i. any metals..... Yes / No
   j. any latex materials..... Yes / No
4. Hepatitis..... Yes / No
5. Jaundice (yellow skin and eyes)..... Yes / No
6. Epilepsy..... Yes / No
7. Arthritis..... Yes / No
8. Venereal disease..... Yes / No
9. Rheumatic fever..... Yes / No
10. Scarlet fever..... Yes / No
11. Anemia or other blood disorders..... Yes / No
12. Prolonged bleeding due to a slight cut..... Yes / No
13. Kidney disease..... Yes / No
14. Diabetes..... Yes / No
15. Stomach or duodenal ulcer..... Yes / No
16. Liver disease..... Yes / No
17. Tuberculosis..... Yes / No
18. Emphysema..... Yes / No
19. Thyroid or parathyroid disorders..... Yes / No
20. Heart trouble..... Yes / No
21. Heart murmur..... Yes / No
22. Arteriosclerosis..... Yes / No
23. High blood pressure..... Yes / No
24. Low blood pressure..... Yes / No
25. Excessively swollen ankles..... Yes / No
26. A stroke..... Yes / No
27. Shortness of breath on mild exertion..... Yes / No
28. Chest pains on mild exertion..... Yes / No
29. Hives, skin rash, hay fever..... Yes / No
30. Asthma..... Yes / No
31. Emotional problems or tention..... Yes / No
32. Psychiatric treatment..... Yes / No
33. A tumor or abnormal growth..... Yes / No
34. Radiation treatment by cobalt, radium x-ray..... Yes / No
35. Glaucoma..... Yes / No
36. Contact lenses..... Yes / No
37. Prostate disorders (if male)..... Yes / No
38 HIV Positive (Acquired Immune Deficiency Syndrome)..... Yes / No

ARE YOU:

39. Presently being treated for any illness..... Yes / No
40. Taking any medication regularly now or within the past year..... Yes / No
41. Aware of a change in your general health in the past year..... Yes / No
42. Aware of any recent weight change..... Yes / No
43. Often thirsty..... Yes / No
44. Urinating more than six times per day..... Yes / No
45. Often exhausted and fatigued..... Yes / No
46. Subject to frequent headaches..... Yes / No
47. A heavy smoker (1 package or more of cigarettes per day)..... Yes / No
48. Generally a nervous person..... Yes / No
49 Often unhappy and depressed..... Yes / No

IF FEMALE, ARE YOU NOW:

50. Pregnant..... Yes / No
51. Taking birth control pills or other hormones..... Yes / No
52. Presently in the menopause ("change of life")..... Yes / No
53. Past menopause..... Yes / No

PLEASE EXPLAIN FULLY ANY YES ANSWERS ABOVE.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST.

PATIENT'S SIGNATURE _____ DATE _____

Reviewed by	Date	Reviewed	Date