MEDICAL HISTORY FOR _____________________________ Date _____________

Physician's Name:_______________________________ Phone: ____________________

Physician's Address: ____

Have you had any major illnesses, surgery or hospitalizations? _____________________

____

____

Do you take any drugs or medications? ____

____

____

Are you allergic to penicillin? ____________________To Latex/Rubber? ____________

Do you have any other allergies? ____

Have you been asked to take an antibiotic prior to receiving dental treatment? _________

Please check any of the following which you have had or have at the present time:

Abnormal Bleeding	____	Hi Blood Pressure	____
AIDS	____	Heart Attack	____
Anemia	____	Heart Murmur	____
Angina	____	Hepatitis A (infectious)	____
Artificial Heart Valve	____	Hepatitis B (serum)	____
Artificial Joint/Limb	____	MVP	____
Asthma	____	Pacemaker	____
Cancer	____	Prolapsed Valve	____
Chemotherapy	____	Radiation Therapy	____
Diabetes	____	Rheumatic Fever	____
Drug Dependency	____	Sinus Trouble	____
Emphysema	____	Stroke	____
Epilepsy	____	Thyroid Disease	____
Fainting Tendency	____	Tuberculosis	____

Do you have any disease, condition or medical situation not listed above? ___________

____

____

Women: Are you pregnant now or think you may be pregnant? Yes ____ No _____

PLEASE INFORM THE OFFICE IF THERE IS ANY CHANGE IN YOUR HEALTH OR MEDICATIONS.

Signature of patient: _______________________________________ Date ________________