



**YOUR CURRENT PHYSICAL HEALTH IS:**

Good       Fair       Poor

Primary Care Physician:

\_\_\_\_\_

Physician's Phone #: \_\_\_\_\_

**FOR WOMEN:**

Do you take birth control:      Yes      No

Are you currently pregnant:      Yes      No

If yes, how many weeks: \_\_\_\_\_

Are you nursing? \_\_\_\_\_

Have you had any of the following diseases or medical conditions?

Ulcers	Yes	No
Cancer	Yes	No
Heart murmur	Yes	No
Rheumatic Fever	Yes	No
HIV / Aids	Yes	No
Heart Surgery	Yes	No
Pacemaker	Yes	No
Anorexia / Bulimia	Yes	No
Mitral Valve Prolapse	Yes	No
Kidney Disease	Yes	No
Chemo/Radiation Therapy	Yes	No
Artificial Valves/Joints	Yes	No
Sinus Problems	Yes	No
High Blood Pressure	Yes	No
Severe/Frequent Headaches	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No
Drug/Alcohol Abuse	Yes	No
Venereal Disease	Yes	No
Hemophilia	Yes	No
TMJ Problems	Yes	No
Periodontal Disease	Yes	No
Back Pain	Yes	No

***(Medical History Continued)***

Anemia	Yes	No
Asthma	Yes	No
Diabetes	Yes	No
If yes, what type? <b>Type I</b>	<b>Type II</b>	
Epilepsy	Yes	No
Glaucoma	Yes	No
Hepatitis	Yes	No
If yes, what type? A      B      C      D		
Have you ever received a blood transfusion? Yes	No	
If yes, what was the approximate date?		
_____		
Osteoporosis	Yes	No
If yes, what type of medication are you		
Currently taking for this condition?		
_____		

**ALLERGIES:**

Are you allergic to any of the following medications?

Aspirin	Yes	No
Penicillin	Yes	No
Tetracycline	Yes	No
Erythromycine	Yes	No
Codeine	Yes	No
Latex Gloves	Yes	No

Do you have any other allergies? Please list below:

\_\_\_\_\_

\_\_\_\_\_

**MEDICATION LIST:**

Name	Dose	Reason
_____		
_____		
_____		
_____		
_____		
_____		

**The answers given to these questions are for my dental records only, and are to be considered confidential. The information is complete, to date, and you have my permission to discuss any portion of it with my physician. I understand that it is my responsibility to inform this office of any and all changes in my medical or personal information, including changes of address and changes in insurance companies or coverage status.**

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date