DATE:	

MEDICAL HISTORY

NAME:		ADDRESS:			
CITY:		STATE:		ZIP CODE:	
HOME PHONE:		BUSINESS PHONE:			
DATE OF BIRTH:		SEX:		HEIGHT:	WEIGHT:
MARRIED ❒	SINGLE ❒	NAME OF SPOUSE:			
CLOSEST RELATIVE		PHONE:			
OCCUPATION:		SOCIAL SECURITY N°:			
REFERRED BY:	PATIENT❒ POST CARD❒ NEWS PAPER❒ YELLOW PAGES ❒ RADIO/TV ❒ OTHER❒				

For the following questions, circle ***yes*** or ***no***, whichever applies. Your answers are for our records only, and will be considered confidential. Please note that during your first visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1.	Are you in a good health ?	YES	NO
2.	Are you under a physician's care?	YES	NO
	If you answer yes to question 2 please give the following information:		
	Physician's name: Physician's Phone:		
	What is the condition being treated :		
3.	Are you taking any medication, including non-prescription ?:	YES	NO
4.	Have you had any serious illness, operation, or been hospitalized in the past **5** years ?	YES	NO
	If so what had been the cause?		
5.	Do you have or have you had damaged heart valve or artificial heart valve including heart murmur ?	YES	NO
6.	Do you have or have you had rheumatic heart disease, heart attack, coronary disease ?	YES	NO
7.	Do you have high blood pressure ?	YES	NO
8.	Do you have a cardiac pace maker ?	YES	NO
9.	Do you have any **liver** disease or problem or **hepatitis** ?	YES	NO
10.	Do you have any **kidney** disease or problem ?	YES	NO
11.	Do you have any **stomach ulcer or heart burns** ?	YES	NO
12.	Do you have any **lung** disease or respiratory problem or **asthma**?	YES	NO
13	Do you have **Diabetes**?	YES	NO
14.	Do you have **AIDS** or are you infected with **HIV** virus?	YES	NO
15.	Do you have any problem with your **mental** health?	YES	NO
16.	Do you have **Epilepsy** or have you had any **convulsions** or any other neurological disease?	YES	NO
17.	Do you have or have you had any type of **Cancer**?	YES	NO
18.	Have you ever had any treatment for a tumor or growth including **radiation** ?	YES	NO
19.	Have you ever had abnormal bleeding when suffer from small accidental cuts?	YES	NO
20	Do you have any bleeding problem?	YES	NO

Patient Signature_____

21.	Are you allergic or have you ever had a reaction to **Local Anesthetics**?	YES NO
22.	Are you allergic or have you ever had a reaction to **Penicillin** ?	YES NO
23.	¿Are you allergic or have you ever had a reaction to **Sulfas** ?	YES NO
24.	Are you allergic or have you ever had a reaction to other **antibiotics**?	YES NO
25.	Are you allergic or have you ever had a reaction to **Aspirin**?	YES NO
26.	Are you allergic or have you ever had a reaction to **Iodine**?	YES NO
27.	Are you allergic or have you ever had a reaction to **Codeine** or other **narcotics**?	YES NO
28.	Are you allergic or have you ever had a reaction to any other medication/food not listed above?	YES NO
29.	Have you been diagnosed with **osteoporosis** or any other bone disease?	YES NO
30.	Are you taking now or within the last **10 years** any of the following medications. (Brand Name/Generic)	YES NO
	Fosamax ❑ Boniva❑ Bonefos❑ Ostac❑ Didronel❑ Aredia❑ Actonel❑ Skelid❑ Zometa ❑	
31.	Have you had any serious trouble associated with any previous dental treatment?	
	If yes please explain:	
32.	Do you have any other disease or condition not listed above?	
	If yes please explain:	
	WOMEN	
33.	Are you **pregnant**?	YES NO
34.	Are you breast-feeding a babe?	YES NO
35.	Are you taken birth pills?	YES NO

CHIEF DENTAL COMPLAINT

_____

Signature of Patient Date

_____

Name of a parent or guardian of a minor

_____

Signature of a parent or guardian of a minor Date

I certify that I have read and understand the above. I acknowledge that my questions ,if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

DOCTOR'S NOTES