Medical History for _____

1. Do you consider yourself to be in good health yes no
2. When was your last physical exam? _____ Your physician's name _____
3. Are you presently being treated for any illness or disease? yes no
4. Please list all prescription and non-prescription medication you have taken in the last 2 months:

5. Please list all surgeries and hospitalizations:

6. Please list any allergies, adverse reactions or intolerance's:

7. Have you had recent exposure to communicable infectious diseases (measles, chicken pox, TB, Prion disease, or travel to an Endemic area) yes no
8. In the last 24 hours have you had new cough, shortness of breath, fever, chills, diarrhea or other flu like symptoms yes no
9. Have you had any of the following? (circle all that are appropriate)

Rheumatic fever	Heart attack	Chronic cough or hoarseness
Heart murmur	Stroke	Shortness of breath
Artificial heart valve	Chest pain/angina	Emphysema
Heart surgery	High blood pressure	Asthma
Pacemaker	Artificial joint	Steroid or cortisone treatment
Blood transfusion	Anemia	Excess bleeding after an extraction
Blood disorder	Hemophilia	Leukemia
Sickle cell disease	Arthritis	Ulcers
Hepatitis	Liver disease	Sexually transmitted diseases (STD's)
Tuberculosis	Jaundice	AIDS or HIV+
Diabetes	Kidney trouble	Prescribed diet
Urinate 8 or more times/day	Sleep apnea	Self imposed diet
Endocrine problem	Thyroid disorder	Food allergies or intolerance's
Problems with eyes	Fainting or dizzy spells	Sinusitis
Glaucoma	Ringing in ears	Hay fever
Contact lenses or glasses	Persistent headaches	Hives
Epilepsy or seizures	Cancer or tumor	Mental illness
Neuralgia	Radiation therapy	Psychiatric treatment
Numbness	Chemotherapy	

10. Women only: Are you?

Pregnant	Taking hormones	Nursing
Taking birth control pills	Anticipating becoming pregnant	

11. Please list your weekly usage of the following:

Tobacco	Alcohol	Recreational drugs

12. Have you had any drug addictions? yes no
13. Is there anything else concerning your health the dentist should know?

To the best of my knowledge, all of the preceding answers are true. If I have a change in health or medications I will inform the dentist as soon as possible. My permission is given to discuss my medical history with my physician.

Signed_____ DATE: _____

Recall History

Please note changes to above questions in a different colored ink

Signed_____ DATE: _____
Signed_____ DATE: _____
Signed_____ DATE: _____