MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

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

1. Hospitalization for illness or surgery in last 5 years……...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
4. Hepatitis…….. Yes No
5. Jaundice (yellow skin and eyes)…… Yes No
6. Epilepsy……...Yes No
7. Arthritis……... Yes No
8. Sexually Transmitted 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 disorder or Acid reflux…….. 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; if you have a murmur have you discussed with your physician the need for pre-medicating?……. Yes No
22. Arteriosclerosis…….. Yes No
23. High blood pressure……... Yes No
24. Low blood pressure……Yes No
25. An artificial valve or joint placed…….. 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 tension……... Yes No
32. Psychiatric treatment……...Yes No
33. A tumor or abnormal growth…….. Yes No
34. Radiation treatment by cobalt, radium x-ray etc….Yes No
35. Glaucoma…… Yes No
36. Contact lenses…… Yes No
37. Prostate disorders (If Male)…… Yes No
38. AIDS (Acquired Immune Deficiency Syndrome).. Yes No
39. ARC or any AIDS related diseases……Yes No
40. Blood transfusion…… Yes No
41. Pacemaker……... Yes No
42. Herpes…… Yes No
43. History of drug or alcohol abuse…… Yes No

ARE YOU:

1. Presently being treated for any illness…….. Yes No
2. Now taking any medication…….. Yes No
3. Aware of a change in you general health ……Yes No
4. Aware of any recent weight change……..Yes No
5. Often thirsty…….. Yes No
6. Urinating more than six times per day……..Yes No
7. Often exhausted and fatigued……Yes No
8. Subject to frequent headaches……...Yes No
9. Smoker, or using any tobacco products…… Yes No
10. Generally a nervous person……Yes No
11. Often unhappy and depressed…… Yes No
12. Taking any naturopathic meds or supplements…… Yes No

IF FEMALE, ARE YOU NOW:

12. Pregnant or nursing……... Yes No
13. Taking birth control pills or other hormones…… Yes No
14. Presently in the menopause ("change of life")……. Yes No
15. 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 Signature: _____ Today's Date:_____

Medical History Update:

Date:	Reviewed By:	Comments:	Patient Initial:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____