

Medical History Information

Check the conditions that apply to you:

yes

- Anemia/Blood Disease
- Arthritis
- Asthma/Hay Fever
- Blood Pressure/High
- Blood Pressure/Low
- Cancer/Tx/X-Ray
- Diabetes
- Epilepsy/Seizures
- _____

yes

- Fainting/Nervous
- Glaucoma
- Heart Trouble
- Pace Maker
- Hepatitis/Liver Disease
- Herpes Virus
- HIV Positive/AIDS
- Joint Replacement
- Migraine Headaches

yes

- Mitral Valve Prolapse
- Neck/Head Pain
- Pregnant
- Rheu Fever/Murmur
- Stroke
- TB/Lung Disease
- TMJ/Clicking Joint
- Venereal Disease
- _____

Allergic to:

yes

- Aspirin
- Codeine
- Local Anesthesia
- Penicillin
- Sedative/Tranq.
- PREMEDICATE**
- MEDICAL ALERT**
- _____

- Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis)
- Are you taking birth control pills?

My medical doctor is _____

Taking Medications Yes No If yes, _____

Prior Unpleasant Dental Treatment _____

General Health Comments _____

The above information is true and complete to the best of my knowledge.

Patient Signature _____ Date _____