Name:	D.O.B.	M	D	Y	Patient/Parent/Guardian Initial:	Date:	M	D	Y

MEDICAL HISTORY: Please circle YES or NO to each question. If unsure of a question, please consult with the dentist.

1. Are you being treated for any medical condition at present or with the past 2 years? If yes, please explain: YES/NO
   _____ Physician: _____ Phone: _____
2. Have you been hospitalized in the past 2 years? _____ YES/NO
3. Last visit to a Physician _____ Last complete physical examination _____
4. Please list all prescription and non-prescription drugs, including herbal remedies
   1. _____ 2. _____ 3. _____
   4. _____ 5. _____ 6. _____
   7. _____ 8. _____ 9. _____
5. Have you ever reacted adversely to any medications or injections? (Please circle) Penicillin, Sulfa, Other Antibiotics, aspirin, codeine, local anaesthetic (freezing), nitrous oxide, general anaesthetic, or any other medicine YES/NO
   _____
6. Have you ever been advised against taking any specific type of medication? _____ YES/NO
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____ YES/NO
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? YES/NO
   If yes, please explain: _____
9. Is there a family history of Diabetes, Cancer, or Heart Disease? (please circle) _____ YES/NO
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____ YES/NO
11. Do your ankles, feet or hands swell? _____ YES/NO
12. Has your weight, appetite or energy level changed dramatically recently? _____ YES/NO
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____ YES/NO
14. Do you have frequent severe headaches, earaches, ear/throat infections? _____ YES/NO
15. Do you wear glasses or contact lenses? _____ YES/NO
16. Do you have any hearing difficulties? _____ YES/NO
17. Have you ever had any injury or surgery to your face or jaws? _____ YES/NO
18. Do you smoke or use any other forms of tobacco? _____ YES/NO
    Are you wearing the transdermal nicotine patch? _____ YES/NO
19. Have you ever tested HIV positive? _____ YES/NO
20. Are you alcohol and/or drug dependent? _____ YES/NO
    Have you received treatment? _____ YES/NO

21. INDICATE (please circle) WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

A.I.D.S.	Glandular disorders	Liver disease
Anemia	Glaucoma	Lung disease
Angina Pectoris	Head/Neck injuries	Lupus
Arthritis/rheumatism	Heart Disease/Heart Attack	Malignant Hyperthermia
Artificial Heart Valve	Heart murmur	Mental/Nervous Disorder
Artificial joints (knee/hip)	Heart pacemaker	Mitral Valve Prolapse
Blood disorders	Heart rhythm disorder	Organ transplant/medical implant
Bronchitis	Heart surgery	Psychiatric treatment
Cancer	Hepatitis A B C	Radiation treatment/chemotherapy
Circulation problems	Herpes (oral/genital)	Scarlet fever/Rheumatic fever
Congenital heart lesions	High/Low blood pressure	Sickle cell disease
Cortisone/steroids	Hodgkins disease	Sinus trouble/surgery
Crohn's disease	Hyper/Hypo glycemia	Stomach/Intestinal problems/ulcers
Diabetes (insulin/pill/diet controlled)	Hypertension	Stroke
Emphysema	Inflammatory bowel disease	Thyroid disease (under/over active)
Epilepsy/seizures	Jaundice	Tuberculosis
Fainting or dizzy spells	Kidney disease	Venereal disease

Has the child patient recently had any of the following (please circle): Measles/Mumps/Chicken Pox/Strep Throat/Tonsillitis
When? _____

22. Do you currently have, or have you had, any disease, condition or problem not listed above? _____ YES/NO
23. Do you wish to speak privately to the Doctor about any problem or medical condition? _____ YES/NO
24. **Women only:** Are you pregnant or suspect you may be? _____ # of Weeks _____ Do you take birth control pills? YES/NO
    Are you breast feeding? YES/NO **Women over 50:** Are you aware of your bone mineral density? _____