

<hr/> Name	<hr/> Age	<hr/> Today's date	<hr/> Approx. date of most recent physical exam
<hr/> Name of personal physician	<hr/> Phone	<hr/> Address or location of clinic	
What is your estimate of your general health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Please list all medical problems for which you are currently under a physician's care or are receiving treatment:		Please list all previous hospitalizations or surgeries, noting only year and reason or type of surgery. Eg. "1975 hernia" :	

Are you allergic, intolerant, or generally have a bad reaction to any of these:  Please circle	penicillin aspirin Advil codeine latex metals erythromycin local anesthetic	Please list any other allergies here:	If you smoke cigarettes how many packs per day? _____ If you chew or use snuff how often per day? _____ Have you ever taken Bisphosphonates? <input type="checkbox"/> yes <input type="checkbox"/> no If you are pregnant, when are you due? _____ Do you usually premedicate with any medication before dental treatment? If so explain:
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	DRUG	DOSE	PURPOSE
List any and all drugs that you are currently taking, including prescription drugs, OTC drugs, and / or street drugs?			

**Do you have, or have you ever had, any of the following? If so, please circle**

- |                       |                                |                         |                      |                         |
|-----------------------|--------------------------------|-------------------------|----------------------|-------------------------|
| Abnormal bleeding     | Chronic backache               | Fainting spells         | High blood pressure  | Psychiatric treatment   |
| Alcoholism            | Chronic digestion problems     | Frequent urination      | HIV or AIDS positive | Rheumatic fever         |
| Artificial joint      | Chronic headache or migraines  | Gastric reflux          | Hypoglycemia         | Rheumatic heart disease |
| Artificial prosthesis | Chronic sore jaw               | Glaucoma                | Jaundice             | Seizures                |
| Anemia                | Congenital heart malformations | Hayfever                | Low blood pressure   | Slow blood clotting     |
| Arthritis             | Delayed healing                | Head or neck injuries   | Night sweats         | Stroke                  |
| Asthma                | Diabetes                       | Heart attack            | Nervous condition    | Trouble breathing       |
| Bruise easily         | Dry mouth                      | Heart trouble or angina | Oral herpes          | Tuberculosis            |
| Bulimea               | Drug abuse                     | Hemophilia              | Osteoporosis         | Ulcers                  |
| Cancer                |                                | Hepatitis               | Pacemaker            | Venereal disease        |
| Canker sores          |                                |                         | Persistent cough     |                         |
| Chest pain            |                                |                         |                      |                         |

I affirm that the information given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status at future dental visits.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date