Patient Name_____ **Today's Date**_____
Home Address_____ **Date of Birth**_____
_____ **Home Phone**_____
Email_____ **Cell Phone** _____
Insurance CO._____ **Business Phone**_____
Primary Language Spoken_____ **SS#**_____

Patient Medical History

Do you have an Advance Directive? Yes or NO

Physician_____ Office Phone _____ Last exam_____

1. Are you under medical treatment now? Yes or NO
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes or NO
3. Are you taking any medication(s) including non-prescription medication? Yes or NO If yes, please provide us with a list of medications._____
   _____
4. Does your child have a mental or physical disability? Yes or NO
5. Do you use tobacco? Yes or NO
6. Do you normally pre-med with an antibiotic prior to dental visits? Yes or NO
7. **Are you allergic to or have you had any reactions to the following? Please circle YES or NO for each:**

Yes/no *Local anesthetics* **yes/no** *Barbiturates* **yes/no** *Aspirin*
Yes/no *Penicillin or other antibiotics* **yes/no** *Sedatives* **yes/no** *Latex*
Yes/no *Sulfa Drugs* **Other:**_____

7. **Do you have or have you had any of the following? Please circle YES or NO for each of the conditions listed below:**

Yes/no *High Blood Pressure*	**yes/no** *Heart Disease*	**yes/no** *Chest Pains*	**yes/no** *Stroke*
Yes/no *Low Blood Pressure*	**yes/no** *Cardiac Pacemaker*	**yes/no** *Easily Winded*	**yes/no** *Tuberculosis*
Yes/no *Fainting/Seizures*	**yes/no** *Angina*	**yes/no** *Asthma*	**yes/no** *Emphysema*
Yes/no *Anemia*	**yes/no** *Diabetes*	**yes/no** *Kidney Disease*	**yes/no** *Glaucoma*
Yes/no *AIDS/HIV infection*	**yes/no** *Leukemia*	**yes/no** *Cancer*	**yes/no** *Arthritis*
Yes/no *Hepatitis/Jaundice*	**yes/no** *STD*	**yes/no** *Liver Disease*	**yes/no** *Heart Trouble*
Yes/no *Respiratory Problems*	**yes/no** *Radiation Therapy*	**yes/no** *Recent Weight Loss*	**yes/no** *Heart Murmur*
Yes/no *Stomach troubles/Ulcers*	**yes/no** *Epilepsy/Convulsions*	**yes/no** *Hay fever/Allergies*	**yes/no** *swollen ankles*

Yes/no *Total Joint replacement*: **Yr**_____ **and what body part**_____

Other_____

8. Women Only:
   a) Are you pregnant or think you may be pregnant? Yes or NO
   b) Are you nursing? Yes or NO
   c) Are you taking birth control pills? Yes or NO
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes or No

I Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature_____ Date: _____
Patient, Parent or Guardian