DENTAL ASSOCIATES

Patient's Name _____
Last First Initial Date of Birth

To our Patients:
Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Your answers are for our records only and will be considered confidential.

CIRCLE THE APPROPRIATE ANSWER

1. Are you in good health?	YES	NO
2. Have you ever had a serious illness, operation, or been hospitalized in the last five years	YES	NO
3. Are you under a physician's care?	YES	NO
If YES, Physician's name: _____		
4. Are you taking any medication at present?	YES	NO
If YES, List under "COMMENTS"		
5. Are you allergic to any medications?	YES	NO
If YES, List under "COMMENTS"		
6. Have you ever been told that you have heart disease?	YES	NO
7. Have you ever been told that you have a heart murmur or a mitral valve prolapse?	YES	NO
8. Have you ever had rheumatic fever or bacterial endocarditis?	YES	NO
9. Do you have high or low blood pressure?	YES	NO
10. Do you have inflammatory diseases, such as arthritis or rheumatism?	YES	NO
11. Have you ever had surgery, radiation treatment, or chem therapy for a tumor, growth, or other condition?	YES	NO
12. Do you have any artificial joints/prostheses?	YES	NO
13. Do you have a heart pacemaker?	YES	NO
14. Have you ever bled excessively following any dental procedure or after being cut or injured?	YES	NO
15. Do you have any lung problems such as emphysema?	YES	NO
16. Have you ever had stomach or kidney problems?	YES	NO
17. Are you diabetic?	YES	NO
18. Do you have asthma?	YES	NO
19. Do you have epilepsy or a seizure disorder?	YES	NO
20. Do you have **AIDS** or have you been told that you are **HIV** positive?	YES	NO
21. Have you had **hepatitis**?	YES	NO
22. Do you have or have you had **T.B.**	YES	NO
23. Do you smoke?	YES	NO
24. Have you been told you have **glaucoma**?	YES	NO
25. Do you, or have you had venereal disease?	YES	NO
26. Do you wear contact lens?	YES	NO
27. Do you faint easily or have you been told that you have low blood sugar?	YES	NO
28. Do you have a latex (rubber) sensitivity?	YES	NO
29. Do you have any disease, condition, or problem not listed?	YES	NO
If so, please explain_____		
_____		
30. Do you have any mental health problems and/or been treated for depression?	YES	NO
31. Would you like to speak with the Doctor privately about any problem?	YES	NO
32. Is there anything else we should know about your health that we have no covered in this form?	YES	NO
WOMEN		
33. Are you pregnant or is there a possibility that you may be pregnant?	YES	NO
34. Are you nursing?	YES	NO
35. Are you taking birth control pills?	YES	NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE: _____ Date: _____

DENTIST'S SIGNATURE: _____ Date: _____

ANEST.

MEDICAL HISTORY

MED ALERT