Name________________________

Medical History

Do you have any of the following medical conditions: Please circle **Y** or **N**

Y	**N**	Mitral Valve Prolapse	**Y**	**N**	Rheumatis/ Arthritis	**Y**	**N**	HIV Test
Y	**N**	Heart Condition	**Y**	**N**	Diabetes (Type I or II)	**Y**	**N**	Venereal Disease
Y	**N**	Stent	**Y**	**N**	Hepatitis	**Y**	**N**	Kidney Condition
Y	**N**	Heart Murmur	**Y**	**N**	Sinus Condition	**Y**	**N**	Tuberculosis
Y	**N**	High Cholesterol	**Y**	**N**	Stroke	**Y**	**N**	Elipsy/Seizures
Y	**N**	High or Low Blood Pressure	**Y**	**N**	Psychiatric Care	**Y**	**N**	Anemia/ Hemophilia
Y	**N**	Cancer (if yes, where)____________________	**Y**	**N**	Chemotherapy	**Y**	**N**	Radiation Therapy

Does your physician require you to pre-medicate for dental appointments? **YES** **NO**

Do you have any prosthetic or artificial joints? (if yes, list them)____

Do you have neck pain or stiffness?_______________Back Pain? **YES** **NO** Where____________________

Do you have jaw or jaw joint pain?______________ Do you have earaches?______________________________

Do you have dry mouth from medications? **YES** **NO**

Are you allergic to any drugs? (if yes, list them) ____

Are you taking any medications? (if yes, list them)____

Are you allergic to any dental anesthetics? (if yes, list them)____

Are you currently under medical treatment? **Y** **N** (if yes, explain)_________________Are you Pregnant? **Y** **N**

When was your last physical examination? _________________Physician or Clinic Name___________________

Have you had any major operations? (if yes, list them)____

Please Sign and Date__________________________________, ______________________

_________________ _________________ _________________ _________________

_________________ _________________ _________________ _________________

_________________ _________________ _________________ _________________