PATIENT'S NAME _____

Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

COMMENTS (Include date, details, initials)

1. When was your last complete physical exam?_____ (Date)
2. Are you under a physician's care? YES NO
3. Are you taking any medications? YES NO
4. Do you have any allergies? YES NO
5. Are you allergic to any medications or substances? YES NO
6. Are you pregnant or suspect you might be? YES NO
7. Do you use birth control medications? YES NO
8. Do you have heart disease? YES NO
9. Have you ever had rheumatic fever? YES NO
10. Are you aware of any heart murmurs? YES NO
11. Do you have a pacemaker or an artificial valve implant? YES NO
12. Do you have high or low blood pressure? YES NO
13. Do you have any blood disorders? YES NO
14. Have you ever bled excessively? YES NO
15. Do you have any stomach or intestnial problems? YES NO
16. Do you have any liver problems? YES NO
17. Do you consume alcoholic beverages? YES NO
18. Have you ever tested positive for hepatitis? YES NO
19. Do you have any kidney problems? YES NO
20. Have you ever had a venereal disease? YES NO
21. Have you tested HIV positive? YES NO
22. Do you have any history of respiratory problems? YES NO
23. Do you have asthma? YES NO
24. Do you have or have you ever had TB? YES NO
25. Do you smoke, chew, or use other forms of tobacco? YES NO
26. Do you have any hormonal problems? YES NO
27. Are you diabetic? YES NO
28. Do you have low blood sugar? YES NO
29. Do you have any inflammatory diseases: arthritis, rheumatism? YES NO
30. Do you have any artificial joints/prosthesis? YES NO
31. Have you ever had major surgery? YES NO
32. Do you have any complications with any forms of anaesthesia? YES NO
33. Have you ever had radiation treatment or chemotherapy? YES NO
34. Have you ever had psychiatric or psychological treatment? YES NO
35. Do you habitually use controlled substances? YES NO
36. Do you have any disease, condition, or problem not listed? YES NO
37. Is there anything else we should know about your health that we have not covered on this form? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE_____ DATE _____

DENTIST'S SIGNATURE_____ DATE _____

Vital Signs

Physical Description of Patient

Nutritional Assessment

Subjective Description of Patient

MEDICAL HISTORY