MEDICAL/DENTAL HISTORY

Patient Name _____ Today's Date_____ Date of Birth_____

1. Physician's Name_____ Clinic/Location _____

2. Other than routine visits, have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? _____

3. Are you taking any medication, drugs or pills now? Yes No
   If yes, please list name and dosage _____

4. Have you ever had a bad reaction or allergy to Penicillin, Clindamycin, antibiotics, or any other drugs? Yes No
   If yes, please list _____

5. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)	Yes No	Ulcers	Yes No	Hepatitis A B C	Yes No
Chest Pain	Yes No	Latex Sensitivity	Yes No	AIDS/HIV Positive	Yes No
Congenital Heart Disease	Yes No	Diabetes	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Murmur	Yes No	Thyroid Problems	Yes No	Blood Transfusion	Yes No
High Blood Pressure	Yes No	Glaucoma	Yes No	Hemophilia	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Bruise Easily	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Liver Disease	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Neurological Disorders	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Epilepsy or Seizures	Yes No
Arthritis/Rheumatism	Yes No	Allergies or Hives	Yes No	Fainting or Dizzy Spells	Yes No
Cortisone Medicine	Yes No	Sinus Trouble	Yes No	Nervous/Anxious	Yes No
Stroke	Yes No	Radiation Therapy	Yes No	Psychiatric/Psychological Care	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Chemotherapy	Yes No	Acid Reflux (Gerd)	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Bisphosphonates	Yes No

6. Do you take blood thinner? Yes No Aspirin daily? Yes No

7. Do you have or have you had any disease, condition, or problem not listed? Yes No
   If yes, please list _____

8. Have you ever used Botox or Dermal Fillers? Yes No
   Are you interested in either of these procedures? Yes No

9. Women - Are you pregnant? Yes ___ Months No

10. What is the reason for your visit today? _____

11. Date and reason for last dental visit_____

SIGNATURE_____ Date_____