PATIENT HEALTH HISTORY

Patient Name: _____ Physician's Name: _____

Physician's Address: _____ Physician's Phone: _____

Patient Pharmacy/Address/Phone: _____

MEDICAL HISTORY

Your comfort and good dental health are dependent upon an accurate knowledge of your medical well being. Many medical situations can affect or be affected by procedures or drugs used for dentistry. Therefore, please fill out the following carefully. Thank You.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Circle any of the following which you have had or do have now:

Heart trouble	Tuberculosis	Glaucoma
Heart murmur	Hepatitis	Venereal Disease
Rheumatic fever	Stroke	Kidney trouble
High blood pressure	Liver trouble	Lung/breathing trouble
Asthma	Blood disorders	Psychiatric treatment
Fainting spell	Excessive bleeding	Radiation therapy
Ulcers	Epilepsy/seizures	Prosthetic joint(s)
Diabetes	Positive to AIDS Virus	Hiatal hernia
Arthritis	Sinus Disease	Alcohol/drug problem

Comments: _____

_____

Are you allergic to any food, drug or medication? Yes No

If yes, what? _____

Are you taking drugs or medication: Yes No

Medication:	Dosage (mg and # per day)	Action:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant? Yes No

If yes, number of months _____

Is there any other information about your health we should know? Yes No

_____

_____

I understand that I am to return to my dentist for permanent restoration of the treated tooth.

Patient (Parent/Guardian) _____ _____

Signature Date

Complete Reverse Side