MEDICAL HISTORY

		CIRCLE	
1.	Are you having pain or discomfort at this time?	YES	NO
2.	Do you feel very nervous about having dental treatments?	YES	NO
3.	Have you ever had a bad experience in the dental office?	YES	NO
4.	Have you been a patient in the hospital during the past two years?	YES	NO
5.	Have you been under the care of a medical doctor during the past two years?	YES	NO
6.	Have you taken any medicine or drugs during the past two years?	YES	NO
7	Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?	YES	NO
8.	Have you ever had any excessive bleeding requiring special treatment?	YES	NO

9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis, Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Genital Herpes
Artificial Joints	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
		Bruise Easily

10.	When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	YES	NO
11.	Do your ankles swell during the day?	YES	NO
12.	Do you use more than 2 pillows to sleep?	YES	NO
13.	Have you lost or gained more than 10 pounds in the past year?	YES	NO
14.	Do you ever wake up from sleep short of breath?	YES	NO
15.	Are you on a special diet?	YES	NO
16.	Has your medical doctor ever said you have a cancer or tumor?	YES	NO
17.	Do you have any disease, condition, or problem not listed?	YES	NO
18.	WOMEN: Are you pregnant now?	YES	NO
	Are you practicing birth control?	YES	NO
	Do you anticipate becoming pregnant?	YES	NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date	Faculty Signature	Signature of Patient, Parent or Guardian

MEDICAL HISTORY / PHYSICAL EVALUATION UPDATE

Date	Addition	Student / Faculty Signatures	