Have you had trouble from previous dental care? []Yes []No
Do you have any unhealed injuries or inflamed areas in or around the mouth? []Yes []No
Have you ever had any reaction or allergic symptoms to Novocain, local or general anesthetics? []Yes []No
Have you ever had any difficult extractions in the past? []Yes []No
Have you ever had prolonged bleeding followed extractions in the past? []Yes []No

MEDICAL HISTORY

Certain illnesses and drug may take it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE THE FOLLOWING: If yes, please check the "YES" box and CIRCLE illness.

		YES	NO
1.	Asthma, hay fever, sinusitis, or other allergies		
2.	Blood pressure or heart problems		
3.	A pacemaker or open heart surgery or heart valve replacement		
4.	Diabetes, liver, kidney, thyroid, or lung problems		
5.	Ulcer or stomach problems		
6.	Hepatitis or Jaundice		
7.	Epilepsy or nervous disorder		
8.	Bleeding or clotting disorder		
9.	Arthritis or hip replacement surgery or prosthetic joint replacement		
10.	Do any wounds heal slowly or present complications?		
11.	Are you presently under the care of a physician? Dr_____ Phone#_____		
12.	When was your last physical exam?		
13.	Have you been hospitalization? Date?		
14.	Have you had X-Ray treatment or chemotherapy?		
15.	Are you presently on a diet or taking supplements?		
16.	Communicable disease? Tuberculosis, Herpes or Venereal?		
17.	Any other illness		
18.	Acquired immune deficiency Syndrome (AIDS)/ A.R.C./HIV Positive		
19.	Are you presently taking any medicine? Specify:		
20.	History of Bisphosphonate(for Osteoporosis) use or treatment? Date:_____		
20.	Women []Are you taking birth control pills? []Are you nursing? []Are you pregnant?		
21.	Check if you have allergies to: []Aspirin []Barbituates []Codeine []local anesthetic []Penicillin []Sulfa []Metal []Latex []Other_____		

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature Date

Doctor's Signature Date