PATIENT NAME____DATE_________________

Last First M

What name do you prefer to be called?_______________________ Male___Female___

EMERGENCY INFORMATION

Name of nearest relative/friend **not** living with you______________________________________

Complete Address____phone______________

MEDICAL HISTORY

Medical doctor's name______________________________Phone number________________

Are you under a doctor's care now? Why?________________________________ Yes No

Have you been hospitalized (within 2 yrs)? (use reverse side if needed)____________________ Yes No

Are you taking any medications, pills, drugs, or aspirin?________________________Yes No

What?____

____

Are you allergic to any medications or substance?_____________________________ Yes No

What?____

Are you pregnant? (women)____ Yes No

Do you need antibiotics before dental appointment?____________________________ Yes No

Are you a tobacco user? If so, do you smoke or chew? ___________________________ Yes No

Please CIRCLE if you have had any of the following:

AIDS/HIV	Emphysema	Joint replacement	Rheumatic fever
Anemia	Epilepsy or seizures	Kidney condition	Shortness of breath
Arthritis	Fainting or dizziness	Liver condition	Sinus condition
Asthma	Hay fever	Low blood pressure	Sleep Apnea
Bleeding excessive	Heart condition	Lymes disease	Stroke
Cancer	Heart Murmur	Malaria	Swelling of feet/ankles
Chest pain	Hepatitis	Multiple Sclerosis	Thyroid condition
Cold sores	High blood pressure	Pain in jaw joints	Tuberculosis
Diabetes	Hypoglycemia	Radiation treatment	Ulcers

Have you ever had any other serious illness not circled above?____________________Yes No

Please describe ____

X____ ***Date*** ___________________________

Patient Signature (Parent or Guardian)

Reviewed by: Doctor:______________________________ Date _________________________

Office Use Only MEDICAL UPDATES

I have read my **MEDICAL HISTORY** dated ______________________ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Signature	Reviewed by

Baseline Blood Pressure _____/______ Date ____________________