MEDICAL HISTORY

1. Are you currently under a physician's care? Yes No

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

2. Are you currently taking any medication? Yes No
   If yes, what kind? _____

3. Do you have any unusual reactions or allergies to any medications or dental anesthetics? Yes No
   If yes, what kind? _____
4. Have you ever had any trouble with prolonged bleeding after surgery? Yes No

5. (Women) Are you pregnant? Yes No

6. Are you now, or have you ever been a victim of domestic violence? Yes No

Please circle any of the following conditions you presently have or have had:

Heart Disease or Attack
Angina Pectoris/Chest Pain
High Blood Pressure
Heart Murmur
Rheumatic Fever
Artificial Heart Valve
Heart Surgery
Sexually Transmitted Disease
Anemia
Hemophilia
Leukemia
Illegal Drug Use

Blood Transfusion
Glaucoma
Epilepsy/Seizures
Psychiatric Treatment
Stomach/Intestinal Ulcers
Hepatitis
Liver Disease
Sinus Trouble
Allergies
Tuberculosis
Asthma

Emphysema
Arthritis
Artificial Joints
Diabetes
Thyroid Disease
Kidney Disease
Stroke
Steroid Therapy
Use Tobacco
Use Alcohol
Tumor or Cancer

Other: _____

DENTAL HISTORY

1. What was the Name and Address of your previous Dentist? _____
   _____
2. When did you last see the Dentist? _____
3. When were your last Dental X-Rays? _____

The following questions are very important to us in helping to provide you with the best dental care possible. These questions are CONFIDENTIAL, however, they may be shared with subsequent treating dentists and physicians. Please let us know if you have any questions regarding this form.

HIV (AIDS)

1. Have you ever tested positive for HIV? Yes No
2. Do you have an increased risk of being HIV positive? Yes No

Thank you

Signed _____ Dentist _____

Date _____