PATIENT HISTORY

_____
(Patient's Name)

CLINICAL BACKGROUND INFORMATION

1. Personal Physician (if any):

_____
Doctor's Name | Town or City | Phone #

2. Approximate Date of Last Medical Examination? _____

3. Approximate Date of Last Dental Examination? _____

4. Do You Have **ANY** History of:

	Please Check (✓) Yes	No
Heart Disease?	☐	☐
High (or Low) Blood Pressure?	☐	☐
Diabetes?	☐	☐
Asthma (or Other Lung Disease)?	☐	☐
Kidney Disease?	☐	☐
Rheumatic Fever/Heart Murmur?	☐	☐
Convulsions?	☐	☐
Hepatitis (or Other Serious Illnesses)?	☐	☐
Reaction to Anesthesia (Any Kind)?	☐	☐
Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐

5. Do You Have Any Drug or Other Serious Allergies? ☐ ☐
(If Yes, Specify **ALL** Allergies):

(a)_____ (c) _____

(b)_____ (d) _____

6. Have You Ever Had Prolonged Bleeding After Cuts or Extractions? ☐ ☐

7. Have You Ever Become Ill or Had Complications Following Dental Treatments? ☐ ☐

8. If You Are a Woman, Are You Pregnant? ☐ ☐

9. Do You Take Any Pills or Medicines? ☐ ☐

10. Do You Take Any of the Following Medications?

Cortisone?	☐	☐
Tranquilizers?	☐	☐
Insulin?	☐	☐
Anti-coagulants (Blood Thinners)?	☐	☐
Anti-hypertensives?	☐	☐

Other (Specify):_____

_____

FOR DOCTOR'S USE ONLY
(Specify, If any are checked yes)

11. If You Have **ANY** Reason to Believe You Are Not Presently in Good Health, if You've Ever Been Hospitalized or Had Any Operations, or if Other Medical Information About You is Important for Us to Know, Please Briefly Explain:

_____

_____

_____

12. **SIGNATURE**: _____
(If patient is a minor, parents or authorized guardian must sign)