

MEDICAL HISTORY

Please check any of the following that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Heart Lesions (Congenital) | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Others |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Nervous Disorders | Do you have any allergies?
If yes, please list: _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neuralgia | Do you smoke or use tobacco
products? _____ |
| <input type="checkbox"/> Excessive Bleeding/
Bruising | <input type="checkbox"/> Pacemaker | Have you ever been
hospitalized? If yes, please
provide the reason: _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnant/Nursing | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Radiation/Chemotherapy | |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Blood Pressure _____ | <input type="checkbox"/> Rheumatic Fever | |

Are you under a physician's care? Yes No What for? _____

Are you taking any medications? What? _____

Family Physician _____ Phone _____

NAME OF THE PATIENT: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DENTIST'S SIGNATURE: _____

FUTURE UPDATES

<p>Are there any changes in your medical history? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what changes? _____ Date: _____ Signature: _____ Dentist's Signature _____</p>	<p>Are there any changes in your medical history? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what changes? _____ Date: _____ Signature: _____ Dentist's Signature _____</p>
<p>Are there any changes in your medical history? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what changes? _____ Date: _____ Signature: _____ Dentist's Signature _____</p>	<p>Are there any changes in your medical history? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what changes? _____ Date: _____ Signature: _____ Dentist's Signature _____</p>