

OTHER INFORMATION

Date of Last Dental Visit: _____

Adverse effects or reaction to: _____

List Medications you are taking: _____

Pharmacy Name & Phone: _____

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING?

Yes | No

Yes	No
	Have you ever had Rheumatic Fever?
	Do you have Hiatal Hernia or Stomach Trouble?
	Do you have Heart Trouble?
	Have you ever had Angina (chest pain)?
	Have you ever had a stroke?
	Have you ever had Kidney Trouble?
	Do you have Arthritis?
	Are you a Diabetic?
	Have you ever had Tuberculosis?
	Have you ever been diagnosed with Cancer?
	Do you have Asthma or Emphysema?
	Do you have Hay Fever, Allergies, or Hives?
	Have you ever had Liver Disease, Yellow Jaundice, or Hepatitis?
	Have you ever had Thyroid Disorder?
	Have you ever had Epilepsy Seizures?
	Difficulties in Hearing or Eye Disease?
	Psychiatric or Nervous Disorder?
	Severe Headaches?
	Have you tested positive for HIV or AIDS?
	Do you drink alcohol? If yes, how much?
	Do you experience frequent fainting?
	Do you have Sinus Trouble?
	Trouble with Extractions?
	Poor experiences with past dentistry?
	Excessive or prolonged Bleeding?
	Anemia or Blood disorder?
	Pregnant? If so, what month? _____