Date_____

Patient's Name_____

1. Has there been any change in your health in the last year? Yes____ No____

2. When was your last medical examination? _____

3. Name, address and phone number of your physician _____

_____

4. Are you presently being treated by a physician? Yes____ No____

If yes, why? _____

5. Have you been hospitalized or had a serious illness within the last 5 years? Yes____ No____

If yes, why? _____

6. Have you had any of the following conditions?

Hepatitis/Jaundice/Liver	Yes ____ No ____	
Rheumatic Fever/Heart Disease	Yes ____ No ____	
Inflammatory Rheumatism	Yes ____ No ____	
Do you have an artificial joint or Heart valve implant?	Yes ____ No ____	
Diabetes	Yes ____ No ____	
Anemia	Yes ____ No ____	
Epilepsy	Yes ____ No ____	
Heart or circulatory disease	Yes ____ No ____	
Heart Murmur	Yes ____ No ____	
Arthritis	Yes ____ No ____	
Asthma or Hay Fever	Yes ____ No ____	
Stomach Ulcers	Yes ____ No ____	_____
Cancer or Tumor	Yes ____ No ____	
High, low or normal Blood Pressure	Yes ____ No ____	_____
Tuberculosis	Yes ____ No ____	
Veneral Disease/AIDS	Yes ____ No ____	
Kidney Disease	Yes ____ No ____	
Fainting Spells or Seizures	Yes ____ No ____	
Sinus Trouble	Yes ____ No ____	
Blood Disorders	Yes ____ No ____	
Have you ever had radiation treatment for any purpose	Yes ____ No ____	Reason _____

8. Are you presently taking any of the following medications?

Antibiotics	Yes ____ No __	If Yes, What? _____
Blood Pressure Medication	Yes ____ No ____	If Yes, What? _____
Tranquilizers	Yes ____ No ____	If Yes, What? _____
Aspirin	Yes ____ No ____	If Yes, What? _____
Digitalis or heart med.	Yes ____ No ____	If Yes, What? _____
Nitroglycerin	Yes ____ No ____	If Yes, What? _____
Anticoagulant	Yes ____ No ____	If Yes, What? _____
Cortisone (Steroids)	Yes ____ No ____	If Yes, What? _____
Antihistamines	Yes ____ No ____	If Yes, What? _____
Insulin	Yes ____ No ____	If Yes, What? _____
Other	Yes ____ No ____	If Yes, What? _____

MEDICAL DENTAL HISTORY