CONFIDENTIAL MEDICAL HISTORY	Patient		Dr
Physician's name		Phone #	
I. Are you in good health? Yes No			
2. When was the last time you had a medica	Il examination?		
Are you presently receiving treatment for	any illness? If yes, please	provide details:	
4. Have you ever been hospitalized? If yes,	please provide details		
5. Do you have any heart or circulatory prob	lems? Yes No	Do you have a pac	emaker? Yes No
6. Have you ever had rheumatic fever? Yes	s No If yes, wh	en	
7. Have you ever been advised to take antib	oiotic pre-medication prior t	o dental treatment?	Yes No
3. Do you have allergies? Seasonal/hayfeve	er Food	Medica	ation
Are you presently taking any kind of med			
Drug		•	
Drug			
Drug			
Have you ever had a reaction to any kind			
12. Please indicate below (√) if you presently☐ AIDS/HIV	☐ Diabetes		sease (Hepatitis/Jaundice)
☐ Alcohol or chemical dependency	☐ Eating disorders ☐ Lung disease/chest pains		
☐ Arthritis or Rheumatism	☐ Epilepsy/seizures ☐Mental or nervous disorder		
☐ Artificial joints or valves	☐ Fainting/dizzy spells ☐Stomach ulcers		
☐ Asthma	☐ High/low blood press	☐ High/low blood pressure ☐Stroke	
☐ Blood transfusion	☐ Hyper/hypo glycemia	hypo glycemia Tuberculosis	
☐ Cancer/radiotherapy/chemotherapy	☐ Kidney disease	□Venerea	l/communicable disease
2. Do you smoke? If yes, how much per day	/?	per week?	
3. Do you grind or clench your teeth? Yes _	No		
Do you suffer from headaches eara-		?	
 Is there any additional information related 			oove?
Patient or guardian's signature	Date	Reviewed by	Date
Medical history update:			
			.
		_	
		Date Date	