Patient's Name | Date of Birth

SMILE DENTAL CENTER MEDICAL HISTORY

Circle

Are you having pain or discomfort at this time? ...... Yes No If yes, Explain ......

Have you been a patient in the hospital during the past two years? ...... Yes No If yes, What Reason ......

Have you been under the care of a medical doctor during the past two years? ...... Yes No If yes, What Reason ......

Have you taken any medicine or drugs during the past two years? ...... Yes No If yes, What ......

Are you allergic to or made sick by penicillin, aspirin, codeine, or any drugs or medications? ...... Yes No If yes, Which ......

Have you ever had any excessive bleeding requiring special treatment? ...... Yes No

Circle Yes (Y) if you had or now have any of the following: otherwise, Circle No (N).

Heart Failure	Y N	**Emphysema**	Y N	**AIDS**	Y N
Heart Disease or Attack	Y N	**Cough**	Y N	**Herpes**	Y N
Angina Pectoris	Y N	**Tuberculosis**	Y N	**Hepatitis**	Y N
High Blood Pressure	Y N	**Asthma**	Y N	**Liver Disease**	Y N
Heart Murmur	Y N	**Hay Fever**	Y N	**Jaundice**	Y N
Mitral Valve Prolapse	Y N	**Sinus Trouble**	Y N	**Blood Trans.**	Y N
Rheumatic Fever	Y N	**Allergies/Hives**	Y N	**Drug Addiction**	Y N
Congenital Heart Lesions	Y N	**Diabetes**	Y N	**Hemophilia**	Y N
Scarlet Fever	Y N	**Thyroid Disease**	Y N	**Cold Sores**	Y N
Artificial Heart Valve	Y N	**X-Ray Treatment**	Y N	**Epilepsy or Seizures**	Y N
Heart Pacemaker	Y N	**Cobalt Treatment**	Y N	**Fainting or Dizzy Spells**	Y N
Heart Surgery	Y N	**Chemotherapy**	Y N	**Nervousness**	Y N
Artificial Joint	Y N	**Arthritis**	Y N	**Psychiatric Treatment**	Y N
Anemia	Y N	**Rheumatism**	Y N	**Sickle Cell**	Y N
Stroke	Y N	**Cortisone Med.**	Y N	**Hypoglycemia**	Y N
Kidney Trouble	Y N	**Glaucoma**	Y N	**Ulcers**	Y N
Dialysis	Y N	**Pain in Jaw**	Y N		

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ...... Yes No

Do your ankles swell during the day? ...... Yes No

Do you use more than 2 pillows to sleep? ...... Yes No

Have you lost or gained more than 10 pounds in the past year? ...... Yes No

Do you ever wake up from sleep short of breath? ...... Yes No

Are you on a special diet? ...... Yes No

Has your medical doctor ever said you have a cancer or tumor? ...... Yes No

Do you feel nervous about having dentistry treatment? ...... Yes No

Have you ever had a bad experience in the dentistry office? ...... Yes No

Do you have any disease, condition, or problem not listed? ...... Yes No

Women: Are you pregnant now? ...... Yes No

Are you nursing? ...... Yes No

Are you presently taking any oral contraceptives, i.e. birth control pills? ...... Yes No

Do you anticipate becoming pregnant? ...... Yes No

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

Date | *Signature (Patient or Guardian)*

Date | *Doctor's Signature*