

MEDICAL HISTORY

THIS IS CONFIDENTIAL MEDICAL INFORMATION

Accurate and complete medical information is needed to help us provide optimum medical care. Have you ever had any of the following? (Check all that apply)

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| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice, Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> AIDS or HIV |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Immunosuppressive Disorders |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease or STDs |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol or Drug Abuse |

Allergies to Medications (including local anesthetics) _____

Type of reaction (hives, swelling, etc.) _____

Describe your Dermatological Problem (what, where, how long, medications and any treatments used): _____

Previous Skin Disorders/Problems: _____

Have you ever had Skin Cancer? Yes No Describe: _____

List any skin problems of other family members: _____

List any other medical problem you are presently or have previously been treated for: _____

List all medications you are presently taking or have taken in the last three (3) months: _____

List all Herbal Supplements/Vitamins you are presently taking: _____

Are you pregnant? _____

Do you plan on becoming pregnant in the near future? _____

Are you nursing/breastfeeding? _____

Are you taking birth control? _____ In what form? _____

Have you been advised by other physicians to take antibiotics before having dental procedure? _____