DENTAL PATIENT MEDICAL HISTORY

NAME *(Last, First, Middle Initial)*	DATE OF BIRTH

1. NAME AND ADDRESS OF MEDICAL DOCTOR: PHONE:	2. YEAR LAST MEDICAL PHYSICAL

3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH APPLY TO YOU PAST OR PRESENT.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (Syphilis, Gonorrhea)
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease	Drug Addiction
Frequent Chest Pains	Overseas Travel* (See bottom)	Emphysema	Glaucoma	Psychiatric Treatment
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Cancer
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Radiation Therapy
Swollen Ankles	Anemia	Ulcers	Osteoporosis	Chemotherapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Implant Prosthesis
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores	Unexplained Weight Loss
Heart Murmur	Arthritis	Jaundice (Other than at Birth)	Genital Herpes	

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. *(IF IN DOUBT, CIRCLE YES)*
(IF YES, please give details.) **CONTINUE COMMENTS ON BACK IF NECESSARY.**

4. ARE YOU PRESENTLY OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?	**YES**	**NO**
5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS?	**YES**	**NO**
6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS?	**YES**	**NO**
7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?	**YES**	**NO**
8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	**YES**	**NO**
9. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	**YES**	**NO**
10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	**YES**	**NO**
11. DO YOU USE TOBACCO (IF YES, please circle and give frequency) **SMOKE:** Cigarettes Cigar Pipe **SMOKELESS:** Chewing Tobacco Snuff or "Dip" **FREQUENCY:**	**YES**	**NO**

12. **WOMEN:** ARE YOU PREGNANT? (If YES, please circle trimester block) **YES** **NO** **TRIMESTER** 1 2 3

I hereby grant authority to Dr. Steven W. Haywood to administer any treatment agreed upon; or to administer such anesthetics and to perform such operations as may be deemed necessary or advisable in a diagnosis and treatment of this patient.

PATIENT COMMENTS (Check this box if you have additional comments on the back of this form) ☐	**SIGNATURE OF PATIENT** (or legal guardian if patient is a minor) X	**DATE** X

DENTIST'S COMMENTS

Reviewer	Date	Reviewer	Date	Reviewer	Date	Reviewer	Date	Reviewer	Date
Reviewer	Date	Reviewer	Date	Reviewer	Date	Reviewer	Date	Reviewer	Date

*Overseas travel last 1-2 years