MEDICAL HISTORY

LAST COMPLETE PHYSICAL ARE YOU TAKING ANY MEDICATION NOW? YESNOPLEASE LIST	GENERAL HEALTH (Please circle one)	Excellent	Good	Fair	Poor	
ARE YOU TAKING ANY MEDICATION NOW? YES NO PLEASE LIST HAYE YOU BEEN TREATED FOR: (Please Check) Heart Disease Rheumatic Fever Abnormal Blood Pressure or Problems Tuberculosis or Lung Disease Diabetes Epilepsy Anemia Congenital Heart Disease Heart Murmur Jaundice Asthma or Hay Fever Sinus Trouble Hepatitis Arthritis Stroke HIV/AIDS Cancer Are you Allergic to: Penicillin Codeine Local Anesthetics Other Medications Are you subject to frainting spells YES NO Do you have frequent headaches YES NO Do you have frequent headaches YES NO Do you jaws feel tired YES NO Do you jaws feel tired YES NO Do you jaws feel tired YES NO Do you jaws feol tired YES NO Do you jaws feol tired YES NO Do you leasn or grind your teeth YES NO What is the reason for this visit? Please add anything that you feel is important DENTAL HEALTH Have you ever had any serious problem associated with previous dental treatment? YES NO When did you have you use? (soft, medium, hard, natural) Brand? What wo often do you flings or break fillings? Do you go avoid brushing any part of your mouth because of pain? If yes, what part? Do you lose fillings or break fillings? Do you you feel is important Denies and anything you feel is	NAME AND ADDRESS OF PHYSICIAN:					
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Do you gag easily?Please add anything you feel is important	Do your gums feel tender or swollen?					
Do you gag easily?Please add anything you feel is important						
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