Patient's Name_____ _____
Last First Initial Date of Birth

Physician's Name/Address_____

Date of your last physical exam_____

UPDATE

Please (X) if you have, or had, any of the following conditions:

_____**High/Low Blood Pressure**	_____**Tuberculosis (T.B.)**
_____**Heart Murmur**	_____**Bleeding Disorder**
_____**Heart Disease**	_____**Epilepsy**
_____**Pacemaker**	_____**Diabetes**
_____**Heart Valve Implant**	_____**Asthma**
_____**Artificial Joints/Prosthesis**	_____**Arthritis**
_____**Radiation or Chemo Therapy**	_____**Hepatitis**
_____**Kidney or Liver Problems**	_____**Venereal Disease**
_____**Stomach Problems**	_____**AIDS/HIV Positive**
_____**Rheumatic Fever**	_____**Thyroid Disease**

Blood Pressure _____/_____

Do you have any ALLERGIES to; or have you had a reaction to:

_____Latex _____Penicillin _____Other Medications or Substances

_____Metals _____Anesthetics List:_____

Yes	No	Have you ever bled excessively through injury or dental procedure?
Yes	No	Are you pregnant or suspect you may be?
Yes	No	Do you smoke or chew tobacco?
Yes	No	Have you ever been treated for drug or alcohol abuse?

List any medications you are taking_____

_____

_____

Please explain any major surgery or serious illness_____

_____

_____

_____

SIGNATURE_____DATE_____

MEDICAL HISTORY