Name: First_____ Last_____

Address Changes: Yes No If Yes: _____
(add address if new patient)

_____

Phone: home _____ work _____ cell _____

e-mail: _____

MHSC# ____ ____ PHIN# ____ ____ ____ D.O.B. d___ m___ y_____

Medical History:

1. How is your health now? _____
2. Is your physician treating you now? Yes No
   If yes, what for? _____
3. Are you taking any medications or tablets? Yes No
   If yes, what? _____
4. Have you ever had an unusual reaction to any medications or drugs? Yes No
   If yes, what? _____
5. Have you ever experienced abnormal bleeding? Yes No
   If yes, when? _____
6. Do you suffer from any allergies? (food, dyes, latex, metal, other) Yes No
   If yes, what? _____
7. Have you had any surgeries? _____
8. Have you ever taken steroids? Yes No When _____
9. Do you use tobacco products? Yes No >10/day <10/day
10. Are you pregnant? Yes No Maybe
11. Do you snore? Yes No Maybe
12. Do you choke or gasp at night? Yes No
13. Are you tired in the morning or during the day? Yes No
14. Do you get headaches? Yes No How often? _____
15. Do you have or have you had? (Circle)

Heart trouble	Diabetes	Cancer	Joint replacement	High Blood Pressure
Blood disorder	Thyroid trouble	Anemia	Heart Murmur	Artificial heart valve
Kidney trouble	Tuberculosis	Liver trouble	Asthma	Hepatitis
Mental or Nervous disease		Epilepsy	Pacemaker	

16. What is your present dental problem? _____
17. When was your last dental visit? _____

Date: _____

Signature: _____

MEDICAL ALERT _____