___ ___ d. Stomach ulcers
___ ___ e. Thyroid condition
___ ___ f. Hepatitis, jaundice or liver disease
___ ___ o. Venereal disease
___ ___ p. Cancer

YES **NO**

___ ___ High blood pressure
___ ___ Low blood pressure
___ ___ Stroke
___ ___ Heart attack
___ ___ Cardiac pacemaker

___ ___ 6. History of alcohol or drug abuse_____
___ ___ 7. Do you have any blood disorders, such as anemia or hemophilia _____
___ ___ 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma _____
_____
___ ___ 9. Have you ever required a blood transfusion _____
___ ___ 10. Have you been tested for HIV/Aids _____
If yes, Positive Negative
___ ___ 11. Are you employed in any situation which exposes you regularly to x-ray or other ionizing radiataion _____
___ ___ 12. Do you wear contact lenses _____
___ ___ 13. Do you have any disease, condition or problem not listed above that you think we should know about
_____
___ ___ 14. Are you pregnant _____-

15. Do you have a problem with or ever had any of the following: Check **YES** or **NO**

YES **NO**

___ ___ Bleeding gums – how long ____
___ ___ Teeth sensitive to hot, cold
___ ___ Teeth sensitive to sweets, chewing
___ ___ Oral habits (fingernail biting, cheek, ect)
___ ___ Frequent blisters on lips or mouth
___ ___ Peridontal treatment
___ ___ Swelling or lumps in mouth
___ ___ Injury to face or teeth
___ ___ Root canal treatment
___ ___ Orthodontic treatment (braces)

DO YOU

___ ___ Brush daily _____ times a day
___ ___ Floss daily _____ times a day
___ ___ Smoke (cigarette, cigar or pipe smoking)

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff responsible for any errors or omission that I may have made in completion of this form.

Sign here_____ **Date** _____

MEDICAL HISTORY REVIEW

Date	Signature	Changes