CHAMBERLAIN
DENTAL HEALTH

Patient Medical History

Patient's Name: ______________________________

Date of birth: ______________________________

Physician's Name: ______________________________

Physician's phone: ______________________________

Please answer the following questions as completely as possible (circle "yes" or "no").

1. Do you consider yourself to be in good health? YES NO
2. Are you now or have you been under a physician's care within the past year? YES NO
3. Do you take any medications, including birth control pills? YES NO
   Please list the name and purpose of each medication: ______________________________
   ____
   ____
4. Do you have or have you ever had any heart or blood problems? YES NO
5. Have you ever been told you have a heart murmur? YES NO
6. Do you require antibiotic premedication for a heart condition, artificial valve, or artificial joint? YES NO
7. Do you have or have you ever had high blood pressure? YES NO
8. Do you bleed or bruise easily? YES NO
9. Have you ever been diagnosed as HIV positive or having AIDS? YES NO
10. Have you ever had hepatitis or liver disease? YES NO
11. Have you ever had any of the following?
    ___Rheumatic Fever ___Rheumatism ___Heart Attack ___Diabetes
    ___Arthritis ___Kidney Disease ___Blood Disorders ___Tuberculosis
    ___Venereal Disease ___Asthma ___Immune System Disorder
    ___Other diseases? If so, please specify:______________________________
12. Have you ever had an unusual reaction to or are you allergic to any of the following drugs?
    ___Penicillin ___Aspirin ___Acetaminophen ___Ibuprofen ___Codeine
    ___Sodium Metabisulfite ___Sulfa Drugs ___Barbiturates
    ___Other:______________________________
13. Are you subject to fainting? YES NO
14. Have you ever had any severe reaction to dental treatment or local anesthetics? YES NO
15. Are you allergic to any local anesthetic? YES NO
    If yes, please specify:______________________________
16. Do you have any other allergies? YES NO
    If yes, please specify:______________________________
17. Have you ever had a nervous breakdown or undergone any psychiatric treatment? YES NO
18. Have you ever received counseling for excessive use of alcohol and/or prescription drugs? YES NO
19. Are you now taking or have you ever taken medication for weight loss (Phen-Fen)? YES NO
20. FOR WOMEN: If you are pregnant, what is your due date:______________________________
21. Are you now in pain? YES NO
22. How long ago did you last see a dentist? ______________________________
23. Who was your previous dentist?______________________________
24. Do you think that your teeth are affecting your general health in any way? YES NO
25. Do you have or have you ever had bleeding or sensitive gums? YES NO
26. Do you participate in any athletic activities? YES NO
    If so, what?______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in health, I will inform the dentist at my next appointment without fail.

Signature:______________________________ Date:____________________

(Patient, legal guardian, or authorized agent of patient)