



117 Grand Avenue
 Hackettstown, New Jersey 07840
 (908) 850-0005

MEDICAL HISTORY: Please Circle

Are you under a physician's care now? Why? Who? _____ Phone# _____ Yes No
 Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
 Have you ever had a serious injury to the head or neck? Discuss _____ Yes No
 Are you taking any medications, pills or drugs? What? _____ Yes No
 Are you on a special diet? Discuss _____ Yes No
 Are you allergic to any medications or substances? Please check box below _____ Yes No

Aspirin Penicillin Codeine Acrylic Metal Latex rubber Other _____

Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

If yes to any of the starred* conditions, please call prior to your appointment... Pre-medication may be required.

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease			Bruise Easily			Emphysema		
Heart Murmur*			Anemia			Tuberculosis		
Irregular Heartbeat			Excessive Bleeding			Cancer		
Angina / Chest Pain			Sickle Cell Disease			Radiation Treatment		
Heart Attack/ Failure			Hemophilia			Chemotherapy		
Congenital Heart disorder			Leukemia			Stomach/ Intestinal Disease		
Mitral Valve Prolapse*			Recent Blood Transfusion			Ulcers		
Scarlet Fever			Swelling of Limbs			Recent Weight Loss		
Rheumatic Fever*			Lung Disease			Frequent Diarrhea		
Artificial Heart Valve*			Breathing Problem			Diabetes		
Heart Pace Maker*			Shortness of Breath			Excessive Thirst		
Heart Surgery*			Frequent Cough			Hypoglycemia		
High Blood Pressure			Hay Fever			Liver Disease		
Low Blood Pressure			Sinus Trouble			Hepatitis A (infectious)		
Blood Disease			Asthma			Hepatitis B or C		
Yellow Jaundice			Cold Sores			Thyroid Disease		
Kidney Problems			Fever Blisters			Parathyroid disease		
Renal Dialysis			Herpes			Arthritis/ Gout		
Venereal Disease			Stroke			Rheumatism		
AIDS			Convulsions			Pain in Jaw Joints		
HIV Positive			Epilepsy or Seizures			Cortisone Medicine		
Genital Herpes			Fainting or Dizziness			Glaucoma		
Drug Addiction			Nervousness			Tumors or Growths		
Allergies (Medicines)			Psychiatric Care			Alzheimer's Disease		
Allergies (Pollen or Dust)			Hives or Rash					

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

X _____ **Date** _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ **Date** _____

Significant Findings _____
