



50/50

MEDICAL HISTORY	
Certain medical conditions can affect dental treatment and vice versa.	
Please complete this form by answering the questions.	

All details will be strictly confidential.	Yes	No	Others, Please Specify
Are you under a physician's care now?		<input checked="" type="checkbox"/>	
Are you taking any medications, pills, or drugs?		<input checked="" type="checkbox"/>	
Have you ever been hospitalized or had a major operation?		<input checked="" type="checkbox"/>	
Have you ever had any complications following dental treatment?		<input checked="" type="checkbox"/>	
Are you a smoker?	<input checked="" type="checkbox"/>		

Are you allergic, or have you reacted adversely to any of the following:	Yes	No	Others, Please Specify
Local anesthetics (Novocaine)		/	
Penicillin or other antibiotics		/	
Asperin or Ibuprofen		/	
Reactions to metals		/	
Latex or rubber dam		/	
Foods		/	

Additional questions for women.	Yes	No	Others, Please Specify
Are you pregnant or trying to get pregnant?		<input checked="" type="checkbox"/>	
if yes, expected delivery date: _____			
Are you taking oral contraceptives?		<input checked="" type="checkbox"/>	

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



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