Medical History *(Please complete form and submit to instructor emails listed in syllabus*

Name (first):	(middle):	(last):
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	

Are you in good health? *(Mark Yes or No with an "X")*	**Yes**		**No**	
Date of last physical examination…				
List any health changes occurring in the past year:	None			
Are you currently under the care of a physician?	**Yes**		**No**	
If yes, list condition(s) for which you are being treated:				
Have you been hospitalized or had a serious illness in the past 2 years?	**Yes**		**No**	
If yes, please list condition(s):				
Please list physician(s)' name(s), address(s), and phone number(s):				
Are you taking any prescription and/or non-prescription medications?	**Yes**		**No**	
Please list medication(s) and why medication(s) is taken.				
Have you taken Pondimin, Redux, or Fen Phen?	**Yes**		**No**	
Do you use or have you recently used recreational drugs?	**Yes**		**No**	
Do you have or have you had any of the following diseases or problems?				
Valve(s) damage/ artificial valve(s)/ heart murmur/ rheumatic heart disease?	**Yes**		**No**	
Have you ever been instructed to take Pre-Med before dental treatment? If yes, for what condition is the Pre-Med taken?	**Yes**		**No**	
High blood pressure?				

	Yes		No	
If yes, what was your last BP reading?				
Cardiovascular disease?	Yes		No	
Respiratory problems?	Yes		No	
Emphysema	Yes		No	
Bronchitis	Yes		No	
Asthma	Yes		No	
Do you use an inhaler?	Yes		No	
Artificial implants	Yes		No	
Check if you should Pre-med?	Yes		No	
If yes, list implant(s):				
Diabetes	Yes		No	
Hepatitis	Yes		No	
Jaundice	Yes		No	
Liver	Yes		No	
AIDS	Yes		No	
HIV	Yes		No	
Immune System Problem	Yes		No	
Epilepsy	Yes		No	
Neurological condition	Yes		No	
Fainting spells	Yes		No	
Seizures	Yes		No	
Problems with mental health	Yes		No	
Blood disorders	Yes		No	
Abnormal bleeding	Yes		No	
Cancer	Yes		No	
Arthritis	Yes		No	
Painful swollen joints	Yes		No	
Low blood pressure	Yes		No	
Kidney trouble	Yes		No	
Tuberculosis	Yes		No	

Sexually transmitted disease	**Yes**		**No**	
Thyroid problems	**Yes**		**No**	
Allergy(s)	**Yes**		**No**	
Local anesthetic problem/ complications	**Yes**		**No**	
Are you allergic to or have you had a reaction to any of the following:				
Latex	**Yes**		**No**	
Local injected anesthetics	**Yes**		**No**	
Esters/ topical anesthetics	**Yes**		**No**	
Other (please list):	**Yes**		**No**	
If yes, please list other allergy(s):				
Do you have any disease, condition or problem not listed above?	**Yes**		**No**	
If yes, list condition(s)/ problem(s):				
Are you pregnant/ trying to get pregnant/ nursing?	**Yes**		**No**	
Immunization/ Vaccination History: Verification of Hep-B and CPR is mandatory to participate in this CE course.				
Hep-B: 1st **2nd:** **3rd:**				
CPR Date:				
Patient Signature:				
Supervising Hygienists signature:				