Medical Profile/History

Patient: Family Dr: Date :

Yes	No	Question
[	[	1. Have you been under the care of physician recently?
[	[	2. Have you ever had a serious illness or hospitalized for operation ?
[	[	3. Have you ever had any type of Allergy, Hay Fever and Asthma?
[	[	4. Have you ever had adverse reaction to a drug?
[	[	5. Are you taking any medication at present?
[	[	6. Have you ever fainted?
[	[	7. Do you bleed easily or do cuts in your skin stay open a long time?
[	[	8. Do you have any pains in the chest?
[	[	9. Have you ever had Heart Disease, High Blood Pressure, Diabetes, Kidney, Hepatitis(A, B, etc.), Epilepsy?
[	[	10. Have you ever had any injury, surgery or x-ray therapy to the face or jaws?
[	[	11. Woman - Are you pregnant? are you taking any oral contraceptives?
[	[	12. Are you presently in good health?
[	[	13. When was your last medical checkup ?
[	[	14. Are you being treated for any medical condition at this time ?
[	[	15. Do You have a prosthetic or artificial joint ?

[[16. Do you have a condition or therapies that can affect your immune system ?

[[17. Do you have hepatitis, jaundice, AIDS, or liver disease ?

[[18. Do you have bleeding problem ?

[[19. Do you have any condition or medical problem that run in your family ?

[[20. Do you smoke or chew tobacco products ?

[[21. Are you nervous during dental treatment ?

[[22. Do you Snore ?

[[23. Do you have Sleep Apnea ?

[[24. Have you ever had Sleep Study done ?

[[25. For women, are you pregnant or breastfeeding ?

[[26. Anything we have not asked you ?