10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you ever had a treatment for a tumor or growth? .... Yes No
12. Are you allergic to or have you had a reaction to:
   a. Local anesthetics .... Yes No
   b. Penicillin or antibiotics .... Yes No
   c. Sulfa drugs .... Yes No
   d. Barbiturates or sleeping pills .... Yes No
   e. Aspirin .... Yes No
   f. Iodine .... Yes No
   g. Codeine or other narcotics .... Yes No
   h. Latex or rubber products .... Yes No
   i. Other .... Yes No
13. Have you had any serious trouble associated with previous dental treatment? .... Yes No
   If so, explain: ______________________ Yes No
   ______________________ Yes No
14. Do you have any other condition or disease you think the doctor should know about? .... Yes No
   If so, explain: ______________________ Yes No
   ______________________ Yes No
15. Are you wearing contact lenses? .... Yes No
16. Are you wearing removable dental appliances? .... Yes No
17. Do you wish to talk with the doctor privately about anything? .... Yes No

Women Only:
If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pill after the course of antibiotics or other medications is completed. Please consult with you physician for further guidance.

18. Are you pregnant or trying to become pregnant? .... Yes No
19. Do you have problems associated with your menstrual period? .... Yes No
20. Are you nursing? .... Yes No
21. Are you taking birth control pills? .... Yes No

Chief Dental Complaint: ______________________
____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: ______________ Patient's Signature: ______________________

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: ______________________

Significant findings from questionnaire or oral interview:

Dental management considerations:

Date: ______________ Doctor's Signature: ______________________

Medical History Update:

Date	Comments	Signature