9. Have you had abnormal bleeding? . . . . . Yes No
   a. Have you ever required a blood transfusion? . . . . . Yes No
10. Do you have any blood disorder such as anemia? . . . . . Yes No
11. Have you ever had any treatment for a tumor or growth? . . . . . Yes No
12. Are you allergic or have you had a reaction to:
   a. Local anesthetics . . . . . Yes No
   b. Penicillin or other antibiotics . . . . . Yes No
   c. Sulfa drugs . . . . . Yes No
   d. Barbiturates, sedatives, or sleeping pills . . . . . Yes No
   e. Aspirin . . . . . Yes No
   f. Iodine . . . . . Yes No
   g. Codeine or other narcotics . . . . . Yes No
   h. Other _____
13. Have you had any serious trouble associated with any previous dental treatment? . . . . . Yes No
   If so, explain _____
   _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . Yes No
   If so, explain _____
   _____
15. Are you wearing contact lenses? . . . . . Yes No
16. Are you wearing removable dental appliances? . . . . . Yes No

Women

17. Are you pregnant? . . . . . Yes No
18. Do you have any problems associated with your menstrual period? . . . . . Yes No
19. Are you nursing? . . . . . Yes No
20. 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 other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history: _____
_____
_____
_____

Significant findings from questionnaire or oral interview: _____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

_____ _____
Date Signature of Dentist

Medical history update:

Date	Comments	Signature