COMPLETE IN INK

DENTAL PATIENT MEDICAL HISTORY

(This Form is Subject to the Privacy Act of 1974 – Use Blanket PAS – DD Form 2005)

NAME *(Last, First, Middle Initial)*	SPONSOR'S SSN	BIRTHDATE	ACTIVE DUTY ONLY *(Circle Correct Responses – Are You Currently On)*
	PATIENT'S SSN	AGE	

ORGANIZATION *(Active Duty)* or Home Address	DUTY PHONE	HOME PHONE	FLYING STATUS?	YES	NO
EMAIL ADDRESS (Military Address)			SDP (PRP, SCI, or PS)?	YES	NO

The Answers To The Following Questions Will Assist The Dentist In Evaluating Your General Health Prior To Providing Your Dental Treatment

PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE

1. WHAT IS YOUR IMPRESSION OF YOUR PRESENT OVERALL HEALTH?	2. YEAR OF LAST MEDICAL PHYSICAL?

3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease	(Syphilis, Gonorrhea)
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma	Drug Addiction
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Cancer
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores	Implant Prosthesis
Heart Murmur	Arthritis	Jaundice (Other than birth)	Genital Herpes	Unexplained Weight Loss

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS *(If in Doubt, CIRCLE YES / if YES, Please Give Details)*
CONTINUE COMMENTS ON BACK IF NECESSARY

4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE PAST YEAR?	Yes	No
5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS (OVER-THE-COUNTER / PRESCRIPTION / HERBAL SUPPLEMENTS)?	Yes	No
6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS (INCLUDING LATEX)?	Yes	No
7. HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHETIC?	Yes	No
8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	Yes	No
9. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT MENTIONED ABOVE?	Yes	No
10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	Yes	No
11. HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS PRIOR TO DENTAL CARE?	Yes	No
12. DO YOU USE TOBACCO? (If Yes, Please Circle Type And Give Frequency) **FREQUENCY**: **SMOKE**: CIGARETTES CIGAR PIPE **SMOKELESS**: CHEWING TOBACCO SNUFF or DIP	Yes	No
13. WOMEN – ARE YOU PREGNANT? (If Yes, Please Circle Trimester) 1 2 3	Yes	No

Check Box If Comments Added To Back Of Form	SIGNATURE OF PATIENT (Or Legal Guardian If Patient is a Minor)	DATE

DENTIST COMMENTS

COMMENTS ON BACK: Yes / No

BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE

DENTIST SIGNATURE	DATE	REVIEWER/DATE	REVIEWER/DATE	REVIEWER/DATE	REVIEWER/DATE