

COMPLETE IN INK

DENTAL PATIENT MEDICAL HISTORY

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

<i>NAME (Last, First, Middle Initial)</i>	<i>SPONSOR'S SSN</i>	<i>AGE</i>	<i>ACTIVE DUTY ONLY (Circle correct responses)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO
<i>ORGANIZATION(Active Duty) OR HOME ADDRESS</i>	<i>DUTY PHONE</i>	<i>HOME PHONE</i>	<i>Currently on: Flying Status? SDP (PRP,SCI, or PS)?</i> <input type="checkbox"/> YES <input type="checkbox"/> 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 HEALTH?	2. YEAR LAST MEDICAL PHYSICAL?
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3. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

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

**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 DURING THE PAST YEAR?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
8. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
9. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
11. DO YOU USE TOBACCO? (If YES, please circle and give frequency) SMOKE: Cigarettes Cigars Pipe SMOKELESS: Chewing Tobacco Snuff or "Dip" FREQUENCY: _____	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

12. WOMAN: ARE YOU PREGNANT? (If YES, please circle trimester block) YES NO 1 2 3

PATIENT COMMENTS <i>(Check this box if you have added comments on the back of this form)</i> <input type="checkbox"/>	SIGNATURE OF PATIENT (or legal guardian if patient is a minor) X	DATE X
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DENTIST'S COMMENTS

(If necessary, continue on reverse and check this box)

BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE	BLOOD PRESSURE	DATE
DENTIST'S SIGNATURE	DATE	REVIEWER	DATE	REVIEWER	DATE	REVIEWER	DATE

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