

Medical History

Patient Name: _____

Medical Alerts:

Are you aware of having an allergic or adverse reaction to any medication or substance? Yes No

If yes, please list _____

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physicians Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Have you been a patient in the hospital during the past five years? Yes No

If yes, for what? _____

Have you taken any medication or drugs during the past two years? Yes No

If yes, please list name and dosage _____

Are you currently taking any medication or drugs? Yes No

If yes, please list name and dosage _____

Indicate which of the following you have had or currently have. Circle 'Yes' or 'No' to each item.

Heart Surgery	Yes	No	Ulcers	Yes	No	Hepatitis A or B	Yes	No
Heart Attack	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Heart Disease	Yes	No	Thyroid Problems	Yes	No	AIDS	Yes	No
Congenital Heart Disease	Yes	No	Glaucoma	Yes	No	HIV Positive	Yes	No
Heart Murmur	Yes	No	Contact Lenses	Yes	No	Cold Sores/ Fever Blisters	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No	Blood Transfusions	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Arthritis/ Rheumatism	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Sinus Trouble	Yes	No	Epilepsy	Yes	No
Stroke	Yes	No	Radiation Therapy	Yes	No	Seizures	Yes	No
Kidney Trouble	Yes	No	Chest Pain	Yes	No	Fainting or Dizzy Spells		
Diet (Special/ Restricted)	Yes	No	Chemotherapy	Yes	No	Nervous/ Anxious	Yes	No
Artificial Joints (Hip, Knee, Etc.)	Yes	No	Tumors	Yes	No	Psychiatric/ Psychological Care	Yes	No

Do you use more than two pillows to sleep? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you have or have you had any disease, condition or problem not listed? Yes No

If yes, please list: _____

Women: Are you pregnant? Yes, _____ Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I also will notify my doctor of any change in my health or medication.

Patient/ Guardian Signature _____ Date _____

Doctor Signature _____ Date _____