

MEDICAL HISTORY

Patient Name _____

Patient Account No. _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

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

3. Are you taking any medication, drugs or pills now? Yes No

If yes, please list name and dosage _____

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

If yes, please list: _____

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

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

- | | | |
|--|---------------------------------------|---|
| Heart (Surgery, Disease, Attack) Yes No | Ulcers Yes No | Hepatitis A - B - C Yes No |
| Chest Pain Yes No | Diabetes Yes No | Venereal Disease Yes No |
| Congenital Heart Disease Yes No | Thyroid Problems Yes No | A.I.D.S. Yes No |
| Heart Murmur Yes No | Glaucoma Yes No | H.I.V. Positive Yes No |
| High Blood Pressure Yes No | Contact lenses Yes No | Cold Sores/Fever Blisters Yes No |
| Mitral Valve Prolapse Yes No | Emphysema Yes No | Blood Transfusion Yes No |
| Artificial Heart Valve Yes No | Chronic Cough Yes No | Hemophilia Yes No |
| Heart Pacemaker Yes No | Tuberculosis Yes No | Sickle Cell Disease Yes No |
| Rheumatic Fever Yes No | Asthma Yes No | Bruise Easily Yes No |
| Arthritis/Rheumatism Yes No | Hay Fever Yes No | Liver Disease Yes No |
| Cortisone Medicine Yes No | Latex Sensitivity Yes No | Yellow Jaundice Yes No |
| Swollen Ankles Yes No | Allergies or Hives Yes No | Neurological Disorders Yes No |
| Stroke Yes No | Sinus Trouble Yes No | Epilepsy or Seizures Yes No |
| Diet (Special/ Restricted) Yes No | Radiation Therapy Yes No | Fainting or Dizzy Spells Yes No |
| Artificial Joints (hip, knee, etc.) Yes No | Chemotherapy Yes No | Nervous/Anxious Yes No |
| Kidney Trouble Yes No | Tumors Yes No | Psychiatric/Psychological Care Yes No |
| | Have You Used Phen-Phen? Yes No | Drug or Alcohol Addiction Yes No |

7. Do you have any sleep disorders or do you snore? Yes No

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

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

If yes, please list: _____

10. **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 will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____