

## Medical History

Patient Name \_\_\_\_\_

1. Have you ever 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 ever 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 the present.
 

Heart (Surgery, Disease, Attack)	Yes	No	Diabetes	Yes	No	HIV/ AIDS	Yes	No
Congenital Heart Disease	Yes	No	Chest Pain	Yes	No	Sickle Cell Disease	Yes	No
Heart Murmur	Yes	No	Bruise Easily	Yes	No	Epilepsy/Seizures	Yes	No
High Blood Pressure	Yes	No	Lung Problems	Yes	No	Hepatitis: Type _____	Yes	No
Mitral Valve Prolapse	Yes	No	Stroke	Yes	No	Liver Disease	Yes	No
Artificial Joints (Knee, Hip, Etc)	Yes	No	Pace Maker	Yes	No	Nervous/Anxious	Yes	No
Allergies or Hives	Yes	No	Anemia	Yes	No	Thyroid Problems	Yes	No
Rheumatic Fever	Yes	No	Emphysema	Yes	No	Fainting/Dizzy Spells	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Kidney Problems	Yes	No
Drug/Alcohol Addiction	Yes	No	Asthma	Yes	No	Acid Reflux	Yes	No
Sensitivity to Anesthetics	Yes	No	Sinus Trouble	Yes	No	Arthritis/Rheumatism	Yes	No
Swollen Ankles	Yes	No	Bulimia	Yes	No	Tumors/Cancers	Yes	No
Sexually Transmitted Diseases	Yes	No	Ulcers	Yes	No	Psychiatric Care	Yes	No
Stomach/Digestive Problems	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Excessive bleeding/Hemophilia	Yes	No	Contact Lenses	Yes	No	Diet (Special/Restricted)	Yes	No
Latex Allergy	Yes	No						
7. Have you had any unusual skin reaction to jewelry or other metals? Yes No
8. Have you had surgery, radiation, or chemotherapy treatment? Yes No
9. Do you smoke cigarettes or use smokeless tobacco? Yes No  
 How long? \_\_\_\_\_ How much per day? \_\_\_\_\_
10. Do you drink alcoholic beverages? Yes No  
 How much per week? \_\_\_\_\_
11. Have you ever taken the diet drugs Fen-Phen or Redux? Yes No
12. Do you have any other disease, condition, or medical problem not listed above? Yes No  
 If yes, please explain \_\_\_\_\_
13. Have you been told by a physician you need to take antibiotics prior to dental treatment? Yes No
14. Women are you: Pregnant? Yes \_\_\_ Month \_\_\_\_\_ 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	Blood Pressure _____
	_____
Doctor's Signature _____	Date _____