

MEDICAL HISTORY

Patient Name			Medical Alert	
Street	City	Zip	Home Phone #	Work #

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 prescription/over-the-counter drugs 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

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/Colitis Yes No	Hepatitis A,B,C,D, Other Yes No
Chest Pain Yes No	Diabetes Yes No	Syphilis 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
Blood Disorder Yes No	Difficulty Breathing Yes No	Blood Transfusion Yes No
Mitral Valve Prolapse Yes No	Emphysema Yes No	Hemophilia Yes No
Artificial Heart Valve Yes No	Chronic Cough Yes No	Sickle Cell Disease Yes No
Heart Pacemaker Yes No	Unexplained Fever Yes No	Bruise Easily Yes No
Rheumatic fever Yes No	Tuberculosis Yes No	Liver Disease Yes No
Arthritis/Rheumatism Yes No	Night Sweats Yes No	Yellow Jaundice Yes No
Cortisone Medicine Yes No	Asthma Yes No	Neurological Disorders Yes No
Swollen Ankles Yes No	Hay Fever Yes No	Epilepsy or Seizures Yes No
Stroke Yes No	Latex Sensitivity Yes No	Fainting or Dizzy Spells Yes No
Diet (Special/Restricted) Yes No	Allergies or Hives Yes No	Nervous/Anxious Yes No
Artificial Joints (hip, knee, etc.) Yes No	Sinus Trouble Yes No	Psychiatric/Psychological Care Yes No
Kidney Trouble Yes No	Radiation Therapy Yes No	Chemotherapy Yes No
Fen-Phen Yes No	Tumors Yes No	Bisphosphonates Yes No <small>(Fosamax, Actonel, Boniva, Aredia, Zometa)</small>

7. Do you use more than two pillows to sleep? 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 _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature _____ Date _____