

MEDICAL HISTORY

PATIENT NAME: _____

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: _____

2. Have you taken any prescription, herbal, or over the counter medications in the past two years? Yes No

If yes, please list name and dosage: _____

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

If yes, please list: _____

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

Indicate which of the following you have had, or have at present. Check "YES" or "NO" to each item.

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

5. Do you take, or have you taken, the diet drug Phen-Fen or Redux?* Yes No

*If yes to the above, did you have a medical exam for heart issues? _____

6. Are you taking any medication for the treatment of osteoporosis or bone disease? Yes No

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: 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 _____

Dentist Signature _____ Date _____