Medical History

Patient Name: _____

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

If yes, for what?_____

Physician Name_____Phone_____

Address_____City_____State_____Zip_____

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

Are you taking any medication or drugs currently, including regular doses of asprin or over-the-counter herbal medicines?_____Yes ☐ No ☐

If yes, please list name and dosages_____

_____

Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (Fenluramine); and Redux (dexfenfluramine)?_____Yes ☐ No ☐

If yes, did you have a medical exam for heart issues?_____Yes ☐ No ☐

Are you aware of having an allergic (or adverse) reaction to any medication or substance?_____Yes ☐ No ☐

If yes, please list:_____

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

Have you ever or are you now taking the following medications; oral Bisphosphates (i.e. Fosamax) or Chemotherapy Agents (i.e. Zometa or Areolia)?_____ Yes ☐ No ☐

Indicate which of the following you have had, or have at present. **Check** yes or no to each item.

Ulcers	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐	Hepatitis A B C (circle)	Yes ☐	No ☐
Chest Pain	Yes ☐	No ☐	Congenital Heart Disease	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐
Diabetes I , II	Yes ☐	No ☐	Swollen Ankles	Yes ☐	No ☐	Heart (Surgery, Disease,Attack)	Yes ☐	No ☐
A.I.D.S.	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐	Cold Sores/Fever Blisters	Yes ☐	No ☐
Hay fever	Yes ☐	No ☐	Contact Lenses	Yes ☐	No ☐	Artificial Joints (hip, knee,____)	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Heart Pacemaker	Yes ☐	No ☐	Mitral Valve Prolapse	Yes ☐	No ☐
Tumors_____	Yes ☐	No ☐	Cortisone Medicine	Yes ☐	No ☐	Artificial Heart Valve	Yes ☐	No ☐
HIV Positive	Yes ☐	No ☐	Kidney Trouble	Yes ☐	No ☐	Diet (Special/Restricted)	Yes ☐	No ☐
Hemophilia	Yes ☐	No ☐	Nervous/Anxious	Yes ☐	No ☐	Arthritis/Rheumatism	Yes ☐	No ☐
Sinus Trouble	Yes ☐	No ☐	Blood Transfusion	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐
HeartMurmur	Yes ☐	No ☐	Sickle Cell Disease	Yes ☐	No ☐	Latex Sensitivity	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Yellow Jaundice	Yes ☐	No ☐	Neurological Disorders`	Yes ☐	No ☐
ChronicCough	Yes ☐	No ☐	Allergies or Hives	Yes ☐	No ☐	Epilepsy or Seizures	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐	Radiation Therapy	Yes ☐	No ☐	Fainting or Dizzy Spells	Yes ☐	No ☐
Bruise Easily	Yes ☐	No ☐	Chemotherapy	Yes ☐	No ☐	Psychiatric/Psychological Care	Yes ☐	No ☐
Endocarditis	Yes ☐	No ☐	Marijuana Use	Yes ☐	No ☐	St. John's Wort Use	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 or think you may be pregnant?_____ Yes ☐ No ☐

Women: Do you use birth control medications?_____ 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 dentist of any changes in my health or medication.

Patient/Guardian Signature: _____ Date: _____

History Review:_____

_____

_____

Dentist Signature: _____ Date: _____