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_____

_____

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?_____When?_____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.

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

_____

Patient updated form signature:

_____ Date:_____

Dentist Signature: _____Date: _____