

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

# Medical History

Patient Account #: \_\_\_\_\_

Medical Alert \_\_\_\_\_

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 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 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.
 

Hear (Surgery, Disease, Attack) .....Yes No	Ulcers .....Yes No	Hepatitis A (infectious) B (serum)....Yes No
Chest Pain .....Yes No	Diabetes .....Yes No	Venereal Disease .....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
Mitral Valve Prolapse.....Yes No	Emphysema .....Yes No	Blood Transfusion.....Yes No
Artificial Heart Valve .....Yes No	Chronic Cough .....Yes No	Hemophilia .....Yes No
Heart Pacemaker .....Yes No	Tuberculosis .....Yes No	Sickle Cell Disease .....Yes No
Rheumatic Fever .....Yes No	Asthma .....Yes No	Bruise Easily.....Yes No
Arthritis/Rheumatism .....Yes No	Hay Fever .....Yes No	Liver Disease .....Yes No
Cortisone Medicine .....Yes No	Latex Sensitivity .....Yes No	Yellow Jaundice .....Yes No
Swollen Ankles .....Yes No	Allergies or Hives .....Yes No	Neurological Disorders .....Yes No
Stroke .....Yes No	Sinus Trouble .....Yes No	Epilepsy or Seizures .....Yes No
Diet (Special/Restricted) .....Yes No	Radiation Therapy .....Yes No	Fainting or Dizzy Spells .....Yes No
Artificial Joints (hip, knee, etc.) .....Yes No	Chemotherapy .....Yes No	Nervous/Anxious .....Yes No
Kidney Trouble .....Yes No	Tumors .....Yes No	Psychiatric/Psychological Care .....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.** 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 \_\_\_\_\_

## History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_