MEDICAL HISTORY

Patient Name	Medical Alert

Are you under the care of a medical doctor? ..... **Yes** **No**

If yes, for what? _____

Physician's Name _____ **City** _____

Are you taking any medication, drugs or pills now? ..... **Yes** **No**

If yes, please list name and dosage _____

_____

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 the past year? ..... **Yes** **No**

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	Yes	No	Venereal Disease	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	A.I.D.S.	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Heart 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	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Osteoporosis	Yes	No
			Hepatitis A (infectious) B (serum)	Yes	No	Bisphosphonates	Yes	No

Have you gained or lost more than 10 pounds in the past year? ..... **Yes** **No**

Do you have or had any disease, condition, or problem not listed? ..... **Yes** **No**

If yes, please list _____

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

Doctor's Signature _____ Date _____

DENTAL HISTORY

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-ray** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____