

Name: _____

DOB: / /

MEDICAL HISTORY

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

If yes, for what? _____

Physician's Name _____ City _____

Are you taking any medications, drugs or pills? Yes No If yes, please list names and dosage

Allergies to any medications or substance? Yes No

Heart (surgery,disease, attack)	Yes No	Ulcers	Yes No	Venereal Disease	Yes No
Artificial Joints (hip,knee, etc.)	Yes No	Diabetes	Yes No	A.I.D.S	Yes No
Chest Pain	Yes No	Thyroid Problems	Yes No	H.I.V Positive	Yes No
Congenital Heart Disease	Yes No	Glaucoma	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Murmur	Yes No	Contact Lenses	Yes No	Blood Transfusion	Yes No
High Blood Pressure	Yes No	Emphysema	Yes No	Hemophilia	Yes No
Mitral Heart Prolapse	Yes No	Chronic Cough	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Tuberculosis	Yes No	Bruise Easily	Yes No
Heart Pacemaker	Yes No	Asthma	Yes No	Liver Disease	Yes No
Rheumatic Fever	Yes No	Hay Fever	Yes No	Yellow Jaundice	Yes No
Arthritis/Rheumatism	Yes No	Latex Sensitivity	Yes No	Neurological Disorders	Yes No
Cortisone Medicine	Yes No	Allergies or Hives	Yes No	Epilepsy or Seizures	Yes No
Swollen Ankles	Yes No	Sinus Trouble	Yes No	Fainting/Dizzy Spells	Yes No
Stroke	Yes No	Radiation Therapy	Yes No	Nervous/Anxious	Yes No
Diet (special/restricted)	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 been a patient in the hospital the past year? Yes No

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

If yes _____

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 the 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 _____