



# MEDICAL HISTORY

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_ MED 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: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2 Have you taken any medication/ drugs/ supplements/ vitamins during the past two years? \_\_\_\_\_ Yes No

If yes, please list name and dosage: \_\_\_\_\_

3 Which of these medications/ drugs/ supplements/ vitamins are you taking now?  
\_\_\_\_\_  
\_\_\_\_\_

4 Are you aware of having an allergic (or adverse) reaction to any medication or substance (Including, but not limited to: anesthetics, penicillin or other antibiotics, sulfa drugs, sedatives, iodine, aspirin, metals, latex)? \_\_\_\_\_ Yes No

If yes, please list: \_\_\_\_\_

5 Have you been a patient in the hospital during the past five years? \_\_\_\_\_ Yes No

If yes, for what? \_\_\_\_\_

6 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
Chest Pain	Yes	No
Congenital Heart Disease	Yes	No
Heart Murmur	Yes	No
High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Artificial Heart Valve	Yes	No
Heart pacemaker	Yes	No
Rheumatic Fever	Yes	No
Arthritis/ Rheumatism	Yes	No
Cortisone Medication	Yes	No
Swollen Ankles	Yes	No
Diet (Special/Restricted)	Yes	No
Artificial Joints (Hip, Knee, Etc)	Yes	No
Nervous/ Anxious	Yes	No
Psychiatric/ Psychological Care	Yes	No

Ulcers	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No
Glaucoma	Yes	No
Contact Lenses	Yes	No
Emphysema	Yes	No
Chronic Cough	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Latex Sensitivity	Yes	No
Allergies or Hives	Yes	No
Sinus Trouble	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Tumors	Yes	No

Hepatitis A (infectious)	Yes	No
Hepatitis B (serum)	Yes	No
Venereal Disease	Yes	No
H.I.V. Positive/ A.I.D.S.	Yes	No
Cold Sores/ Fever Blisters	Yes	No
Blood Transfusion	Yes	No
Hemophilia	Yes	No
Sickle Cell Disease	Yes	No
Bruise Easily	Yes	No
Liver Disease	Yes	No
Yellow Jaundice	Yes	No
Kidney Trouble	Yes	No
Neurological Disorders	Yes	No
Stroke	Yes	No
Epilepsy or Seizures	Yes	No
Fainting or Dizzy Spells	Yes	No

7 Do you use more than two pillows under your head 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 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. I am aware that all information is confidential.*

Patient/ Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_