Medical History

Patient Name
Medical Alert

Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what?_____
Physicians 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, drugs or pills now? Yes No
If yes, please list names 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? 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	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

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?** 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, which 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 Signature Date