Medical History

Patient Name
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, including regular dosages of aspirin, Vitamins or other nutritional supplements?...Yes No
   If yes, please list name and dosage_____
   _____
4. Have you ever taken prescription or over the counter medications for weight loss (diet pills)?… Yes No
   If yes, did you have a medical exam for heart issues?…… Yes No
5. Have you been a patient in the hospital during the past five years?……..Yes No
   If yes, for what reason(s)? _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Attack	Yes	No	Indwelling Catheter	Yes	No	AIDS	Yes	No
Heart Failure	Yes	No	Ulcers	Yes	No	HIV	Yes	No
Heart Murmur	Yes	No	Colitis	Yes	No	Blood Transfusion	Yes	No
Heart Palpitation	Yes	No	Hives	Yes	No	Hemophilia	Yes	No
Heart Surgery	Yes	No	Diabetes	Yes	No	Sickle Cell Disease	Yes	No
Chest Pains	Yes	No	Thyroid Disease	Yes	No	Bruise Easily	Yes	No
Congenital Heart Lesion	Yes	No	Glaucoma	Yes	No	Liver Disease	Yes	No
High/Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Yellow Jaundice	Yes	No
Headaches	Yes	No	Emphysema	Yes	No	Epilepsy	Yes	No
Mitral Valve Prolapse	Yes	No	Difficulty Breathing	Yes	No	Seizures	Yes	No
Artificial Heart Valve	Yes	No	Lung Disease	Yes	No	Fainting	Yes	No
Pacemaker	Yes	No	Shortness Of Breath	Yes	No	Nervousness	Yes	No
Arteriosclerosis	Yes	No	Tuberculosis	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Asthma	Yes	No	Alcoholism	Yes	No
Anticoagulants(Blood Thinners)	Yes	No	Hay fever	Yes	No	Drug/ Alcohol Dependence	Yes	No
Disease Of Blood	Yes	No	Allergies	Yes	No	Organ Transplant	Yes	No
Bleeding	Yes	No	Chronic Sinus Condition	Yes	No	Hearing Impairment	Yes	No
Rheumatic Fever	Yes	No	Sinus Trouble	Yes	No	Pain In Jaw Joints	Yes	No
Arthritis	Yes	No	Radiation Treatment	Yes	No	Chronic Fatigue Syndrome	Yes	No
Cortisone Medicine	Yes	No	Cancer	Yes	No	Lupus	Yes	No
Stroke	Yes	No	Chemotherapy	Yes	No	Scarlet Fever	Yes	No
Swelling In Ankles	Yes	No	Tumor	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Hepatitis	Yes	No	Sleep- Insomnia or Apnea	Yes	No
Kidney Problems	Yes	No	Venereal Disease	Yes	No	Fibromyalgia	Yes	No

6. Do you use more than two pillows to sleep?……Yes No
7. Have you lost or gained more than 10 pounds in the past year?……..Yes No
8. 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

Are you allergic to or have had difficulty with any of the following substances:

☐ Penicillin ☐ Tetracycline ☐ Latex/Metals
☐ Aspirin ☐ Codeine ☐ Dental Anesthetic
☐ Sulfa ☐ Erythromycin ☐ Other Drugs_____

Do you exercise regularly? Yes No If yes, what do you enjoy doing?_____
Is your nutrition important to you? Yes No Please briefly describe your daily diet (proteins, fats, carbohydrates etc) : _____
_____
_____

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 change in my health or medication

Signature_____**Date**_____
Parent/Guardian Signature_____**Date**_____

History Review

Dentist Signature_____Date_____