

MEDICAL HISTORY

Patient Name _____ Birth Date _____
 Patient SS# _____ Medical Alert _____

1. Have you ever been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
2. Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
3. Have you taken any medication, herbs, supplements or drugs during the past two years? Yes No
4. Do you use Viagra or any other similar drugs? Yes No
5. Are you taking any medication, herbs, supplements regular doses of aspirin or drugs now? Please list: _____
6. I am aware that street drugs (including alcohol) may cause life-threatening reactions with dental procedures. (please initial) _____
7. Have you ever taken any prescription drugs for weight loss, including Fen-Phen; Pondimin; or Redux Yes No
 If yes, did you have a medical exam for heart issues? Yes No
8. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
 If yes, please list _____
Have you ever taken antibiotics before any dental treatment? Yes No

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

Heart (surgery, disease, attack)	Y	N	Ulcers	Y	N	Hepatitis	Y	N
Chest Pain	Y	N	Diabetes	Y	N	Sexually Transmitted Disease	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems /or / Parathyroid	Y	N	AIDS / or HIV Positive	Y	N
Heart Murmur / Irregular Heartbeat	Y	N	Glaucoma	Y	N	Stomach or Intestinal Disease	Y	N
High / Low / Blood Pressure	Y	N	Cold Sores / Fever Blisters	Y	N	Mitral Valve Prolapse	Y	N
Emphysema / or other Lung Disease	Y	N	Blood Transfusion	Y	N	Artificial Heart Valve	Y	N
Hemophilia	Y	N	Heart Pacemaker	Y	N	Tuberculosis	Y	N
Sickle Cell Disease / or Trait	Y	N	Anemia	Y	N	Rheumatic Fever	Y	N
Asthma / or Breathing Problems	Y	N	Arthritis / Rheumatism	Y	N	Hay Fever	Y	N
Liver Disease / Yellow Jaundice	Y	N	Latex Sensitivity	Y	N	Neurological Disorders / Shingles	Y	N
Allergies or Hives	Y	N	Epilepsy or Seizures	Y	N	Stroke	Y	N
Sinus Trouble	Y	N	Fainting or Dizzy Spells	Y	N	Radiation Therapy / or Chemotherapy	Y	N
Nervous / Anxious	Y	N	Artificial Joints (hip, knee, etc)	Y	N	Excessive Thirst / or Dry Mouth	Y	N
Psychiatric/Psychological Care	Y	N	Kidney Trouble	Y	N	Cancer	Y	N
Sensitivity to Dental Anesthetic	Y	N	Frequent Headaches	Y	N	Bruise Easily	Y	N
Contact Lenses	Y	N	Hepatitis A B C (circle)	Y	N	Chronic Cough	Y	N
Alzheimer's Disease	Y	N	Tonsillitis	Y	N	Hypoglycemia	Y	N

9. Do you have or had any disease, condition, or problem not listed? Please list. _____
10. Do you use more than 2 pillows to sleep? Yes No
11. **WOMEN:** Are you Pregnant? Yes No Month _____ 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 dentist of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

Dentist Signature _____ Date _____