

PATIENT MEDICAL HISTORY

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: _____ Telephone: _____
 Address: _____ City: _____ State: _____ Zip: _____
2. Have you taken any medication or drugs in the past two years? Yes | No
3. Are you taking any medication, drugs or pills now? Yes | No
 If yes, list name and dosage: _____
4. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes | No
 If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? Yes | No
6. Have you ever taken the diet drugs Phen-Pen or Redux? Yes | No
7. Do you use more than two pillows to sleep? Yes | No
8. Have you lost or gained more than 10 pounds in the last year? Yes | No
9. Do you have or have you had any disease, condition, or problem not listed? Yes | No
 If so, please describe: _____
10. Women: Are you pregnant? Yes | No If yes, number of weeks? _____ Are you nursing? Yes | No
11. Please indicate by circling YES or NO if you have had or have at present:

Heart (surgery, disease, attack)	YES	NO	Ulcers	YES	NO	Hepatitis A (Infectious) or B (Serum)	YES	NO
Chest Pain	YES	NO	Diabetes	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Thyroid Problems	YES	NO	AIDS	YES	NO
Heart Murmur	YES	NO	Glaucoma	YES	NO	HIV Positive	YES	NO
High Blood Pressure	YES	NO	Contact Lenses	YES	NO	Cold Sores	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	Liver Disease	YES	NO
Arthritis/Rheumatism	YES	NO	Hay Fever	YES	NO	Bruise Easily	YES	NO
Cortisone Medicine	YES	NO	Latex Sensitivity	YES	NO	Yellow Jaundice	YES	NO
Swollen Ankles	YES	NO	Allergies/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

I understand that 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 any further information be needed, you have my permission to ask the respective agency or health care provider, who may release usch information to you. I will notify the doctor of any change in my health or medication.

Patient or Guardian Signature: _____ Date: _____

History Review: _____

Doctor Signature: _____ Date: _____