



MEDICAL HISTORY

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| | |
|---------------------------|--|
| Patient Name _____ | Medical Alert (Office Use Only) _____ |
|---------------------------|--|

Address _____ City _____ Postal Code _____

Phone (home) _____ (cell) _____ Sex M F Age _____ Birth Date ____/____/____
month day year

Adult Patient

Occupation _____

Employer _____

Phone (work) _____

Email _____

Marital Status M S W D

Dental Insurance No Yes Health Card # _____

How did you find about our office? Friend Name _____ Phonebook (Yellow Pages) Newspaper
Flyer Internet Website _____ Other Please Specify _____

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 _____

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? Yes No

If yes, please list the 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 hospitalized in the past five years? Yes No

6. Indicate which of the following you have had, or presently have

- | | | | | | |
|------------------------------------|--|--------------------|--|----------------------------------|--|
| Heart (Surgery, Disease, Attack) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Latex Sensitivity | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chest Pain | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stomach Ulcers | Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital Heart Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yellow Jaundice | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Murmur | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | Venereal Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma | Yes <input type="checkbox"/> No <input type="checkbox"/> | A.I.D.S. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Heart Valve | Yes <input type="checkbox"/> No <input type="checkbox"/> | Emphysema | Yes <input type="checkbox"/> No <input type="checkbox"/> | H.I.V. Positive | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Mitral Valve Prolapse | Yes <input type="checkbox"/> No <input type="checkbox"/> | Chronic Cough | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cold Sores / Fever Blisters | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Pacemaker | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Transfusion | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic Fever | Yes <input type="checkbox"/> No <input type="checkbox"/> | Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemophilia | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis / Rheumatism | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hay Fever | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle Cell Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cortisone Medicine | Yes <input type="checkbox"/> No <input type="checkbox"/> | Allergies or Hives | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bruise Easily | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Swollen Ankles | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Trouble | Yes <input type="checkbox"/> No <input type="checkbox"/> | Neurological Disorders | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stroke | Yes <input type="checkbox"/> No <input type="checkbox"/> | Radiation Therapy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy or Seizures | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diet (Special / Restricted) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Chemotherapy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Fainting or Dizzy Spells | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Joints (hip, knee etc.) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tumors | Yes <input type="checkbox"/> No <input type="checkbox"/> | Nervous / Anxious | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Kidney Trouble | Yes <input type="checkbox"/> No <input type="checkbox"/> | Do You Smoke | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric / Psychological Care | Yes <input type="checkbox"/> No <input type="checkbox"/> |

7. Do you have, or have you had any disease, or problem not listed? Yes No

If yes, please list _____

8. 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 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 representative 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.

Patient / Guardian Signature _____ Date ____/____/____
month day year