MEDICAL HISTORY

Physician's Name _____

Address _____

Are you now under the care of a physician? Yes ☐ No ☐

If yes, for what reason? _____

Are you presently taking any medications/drugs/pills? Yes ☐ No ☐

Have you ever taken a prescription drug for weight loss (i.e. Phen Fen or Redux?) Yes ☐ No ☐

ALLERGIES:

Are you allergic (or have an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ None

☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances

List medications including vitamins, herbal supplements, natural products or over-the-counter drugs taken routinely:

_____

_____

_____

_____

_____

_____

_____

_____

Are you sensitive or allergic to latex? Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon? Have you had any unusual or unexplained reactions during a surgical procedure? Yes ☐ No ☐ Explain _____

Do you have, or have you ever had any of the following: (yes or no)

		Yes	No			Yes	No			Yes	No			Yes	No
1	Heart Disease/Surgery	☐	☐	16	Asthma	☐	☐	31	Leukemia	☐	☐	46	Hepatitis (circle one) Type A B C	☐	☐
2	Heart murmur	☐	☐	17	Shortness of Breath	☐	☐	32	Prolonged Bleeding	☐	☐				
3	Heart pacemaker	☐	☐	18	Respiratory Ailments	☐	☐	33	Hemophilia	☐	☐	47	Ulcers	☐	☐
4	Rheumatic fever	☐	☐	19	Emphysema	☐	☐	34	Sickle Cell disease	☐	☐	48	Stomach Disorders	☐	☐
5	Rheumatic heart disease	☐	☐	20	Sinus Trouble	☐	☐	35	Cancer	☐	☐	49	GERD (gastric reflux)	☐	☐
6	Congenital heart disease	☐	☐	21	Diabetes	☐	☐	36	Tumors	☐	☐	50	Hearing Impaired	☐	☐
7	Artificial heart valve	☐	☐	22	Thyroid Problems	☐	☐	37	Chemotherapy	☐	☐	51	Glaucoma	☐	☐
8	Mitral valve prolapse	☐	☐	23	Kidney Problems	☐	☐	38	Radiation therapy	☐	☐	52	Cortisone medicine	☐	☐
9	Abnormal blood pressure	☐	☐	24	Venereal Disease	☐	☐	39	Neurological disorders	☐	☐	53	Fainting Spells	☐	☐
10	Learning Disability	☐	☐	25	HIV positive/AIDS/ARC	☐	☐	40	Epilepsy	☐	☐	54	Organ Transplant	☐	☐
11	Psychiatric care	☐	☐	26	Alcohol addiction	☐	☐	41	Stroke	☐	☐	55	Removal of Spleen	☐	☐
12	Anorexia	☐	☐	27	Drug Dependency	☐	☐	42	Arthritis/Rheumatism	☐	☐	56	Osteoporosis	☐	☐
13	Bulimia	☐	☐	28	Chemical Dependency	☐	☐	43	Prosthetic Implants	☐	☐	57	Blood Transfusion	☐	☐
14	Lung disease	☐	☐	29	Blood disorders	☐	☐	44	Artificial Joint	☐	☐				
15	Tuberculosis	☐	☐	30	Anemia	☐	☐	45	Liver disease	☐	☐				

DR COMMENTS

Do you currently smoke or use the following tobacco products?

☐ cigarettes ☐ cigars ☐ pipe ☐ chew ☐ none

Have you used tobacco products in the past? Yes ☐ No ☐ How long ago? _____

Do you drink alcoholic beverages? Yes ☐ No ☐ How much? _____ How often? _____

Have you had any other serious illness, hospitalization or accident? Yes ☐ No ☐

If yes, please explain _____

Would you like to speak to the Doctor privately about any problem? Yes ☐ No ☐

WOMEN: Are you pregnant? Yes ☐ No ☐

Do you take any birth control medications? Yes ☐ No ☐

If yes, please note _____

FOR PROVIDER USE ONLY

BP SCREENING: _____

_____

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 any changes in my health or medication.

Patient Signature _____ Date _____

(PARENT/GUARDIAN OF A MINOR)

Doctor Signature _____ Date _____