

# Medical History

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

1. Have you been hospitalized during the last two years? YES                      NO

2. Have you been under the care of a medical doctor during the past two years? YES                      NO

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Specialist's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

3. Do you have to pre-medicate prior to your dental appointment? YES                      NO

4. Are you now taking any medications and/or supplements? If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Are you sensitive or allergic to any medications, latex, or anesthetics? If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicate by circling which of the following you have had or have at present:

Angina	YES	NO	Frequent Headaches	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Condition/Surgery	YES	NO	Thyroid Disease	YES	NO	Hepatitis B and C (serum)	YES	NO
Heart Murmur	YES	NO	Emphysema	YES	NO	Intestinal Disease	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO	Stomach Problems	YES	NO
Pacemaker	YES	NO	COPD	YES	NO	High Cholesterol	YES	NO
Mitral Valve Prolapse	YES	NO	Lung Disease	YES	NO	STI	YES	NO
Artificial Heart Valve	YES	NO	Tuberculosis	YES	NO	HIV Positive	YES	NO
Stroke	YES	NO	Cold Sores/Fever Blisters	YES	NO	AIDS	YES	NO
Autism	YES	NO	Herpes	YES	NO	Blood Transfusion	YES	NO
Scarlet/Rheumatic Fever	YES	NO	Hypoglycemia	YES	NO	Hemophilia	YES	NO
Arthritis	YES	NO	Osteoporosis	YES	NO	Anemia	YES	NO
Rheumatism	YES	NO	Pain in Jaw Joints	YES	NO	Glaucoma	YES	NO
Drug Addiction	YES	NO	Shingles	YES	NO	Liver Disease	YES	NO
Kidney Trouble	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Diabetes A1C:___	YES	NO	Seasonal Allergies/Hives	YES	NO	Fainting or Dizziness	YES	NO
Cancer	YES	NO	Tumors	YES	NO	Nervousness/Depression	YES	NO
Radiation Treatment	YES	NO	Alzheimer's Disease	YES	NO	Artificial Joints Date:___	YES	NO
Chemotherapy	YES	NO	Ulcers	YES	NO	Autoimmune Disease	YES	NO

Describe above listed conditions and any condition(s) not listed:

\_\_\_\_\_

\_\_\_\_\_

Do you smoke? **YES** **NO** How much per week?

Do you drink alcohol? **YES** **NO** How much per week?

**FOR WOMEN ONLY:**

Are you taking any birth control pills? **YES** **NO**                      Are you pregnant? **YES** **NO**                      Trimester \_\_\_\_\_

Are you nursing? **YES** **NO**                      Are you taking any postmenopausal hormone replacement drugs? **YES** **NO**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

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