

# MEDICAL HISTORY

Patient Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Patient's Blood Pressure (office use only) \_\_\_\_\_

Medical Alert (office use only) \_\_\_\_\_

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 \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years? ..... Yes No  
 If yes, which ones? \_\_\_\_\_
3. Are you taking any medication or drugs currently, including regular doses of aspirin, vitamins, or over the counter  
 herbal medicines? ..... Yes No  
 If yes, which ones? \_\_\_\_\_
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine),  
 Pondimen (fenfluramin), and Redux (dexfenfluramine)? ..... Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ..... Yes No  
 If yes, please list \_\_\_\_\_
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

AIDS/HIV ..... Yes No	Diet (special/restricted) ..... Yes No	Osteoporosis Medicine..... Yes No
Allergies or Hives..... Yes No	Emphysema ..... Yes No	Psychiatric/Psychological ..... Yes No
Arthritis/Rheumatism ..... Yes No	Fainting or Dizzy Spells ..... Yes No	Radiation Therapy ..... Yes No
Artificial Joints (hip, knee, etc.) Yes No	Glaucoma ..... Yes No	Rheumatic Fever ..... Yes No
Artificial Heart Valve ..... Yes No	Hay Fever ..... Yes No	Seizures or Epilepsy ..... Yes No
Asthma ..... Yes No	Heart (surgery, disease, attack) . Yes No	Shunts/Stents..... Yes No
Blood Transfusion ..... Yes No	Heart Murmur ..... Yes No	Sickle Cell Disease..... Yes No
Bruise Easily ..... Yes No	Heart Pacemaker ..... Yes No	Sinus Trouble ..... Yes No
Chest Pain..... Yes No	Hemophilia..... Yes No	Stroke ..... Yes No
Chemotherapy ..... Yes No	Hepatitis A B C (circle)..... Yes No	Swollen Ankles ..... Yes No
Chronic Cough ..... Yes No	High Blood Pressure..... Yes No	Thyroid Problems..... Yes No
Cold Sores/Fever Blister..... Yes No	Kidney Trouble ..... Yes No	Tuberculosis/Valley Fever ..... Yes No
Congenital Heart Disease ..... Yes No	Latex Sensitivity..... Yes No	Tumors ..... Yes No
Contact Lenses ..... Yes No	Liver Disease..... Yes No	Ulcers ..... Yes No
Cortisone Medicine ..... Yes No	Mitral Valve Prolapse..... Yes No	Venereal Disease..... Yes No
Diabetes..... Yes No	Nervous/Anxious..... Yes No	Yellow Jaundice..... Yes No
	Neurological Disorders ..... Yes No	

8. Do you use more than two pillows to sleep?..... Yes No
9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Do you have or have you had any disease condition or problem not listed?..... Yes No
11. **Women:** Are you pregnant or think you may be pregnant? ..... Yes \_\_\_\_\_ Months No Nursing? ..... Yes No
12. **Women:** Do you use birth control medications? ..... 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 changes in my health or medications.*

Patient/Guardian Signature

Date