Medical History Information

PATIENT NAME _____

1. Describe your current dental problem(s) _____
2. Are you having pain or discomfort at this time?..... Yes ❒ No ❒
3. Have you been a patient in the hospital during the past two years?..... Yes ❒ No ❒
4. Have you been under the care of a medical doctor during the past **two** years? .....Yes ❒ No ❒
   Physician's Name _____ Phone Number _____
   Address _____
5. Have you taken any medication or drugs in the past two years? .....Yes ❒ No ❒
6. **Are you now taking any medications or drugs?** (includes meds for pain, recreational drugs, & hormones) .. Yes ❒ No ❒
   If yes, please list: _____
7. **Are you currently taking any type of Herbal Supplements? .....** Yes ❒ No ❒
   If yes, please list: _____
8. **Are you sensitive or allergic to any medication or anesthetics? .....** Yes ❒ No ❒
   If yes, please list. _____
9. Have you ever taken the diet drug Phen-Phen? ..... Yes ❒ No ❒

10. Indicate which of the following you have had or have at the present. Please check "yes" or "no" for each item.

	Yes	No		Yes	No		Yes	No
Heart Failure	❒	❒	Cortisone Medicine	❒	❒	Asthma	❒	❒
Heart Disease or Attack	❒	❒	Drug Addiction	❒	❒	Sinus Trouble	❒	❒
Angina Pectoris	❒	❒	Blood Disease	❒	❒	Radiation Therapy	❒	❒
Congenital Heart Disease	❒	❒	Hemophilia	❒	❒	Chemotherapy	❒	❒
***Heart Murmur**	❒	❒	Anemia	❒	❒	Breathing Problems	❒	❒
High Blood Pressure	❒	❒	Sickle Cell Disease	❒	❒	Pain in Jaw Joints	❒	❒
Low Blood Pressure	❒	❒	Bruise Easily	❒	❒	Hepatitis A (infectious)	❒	❒
Arteriosclerosis.....	❒	❒	***Artificial Joints**	❒	❒	Hepatitis B (serum)	❒	❒
***Mitral Valve Prolapse**	❒	❒	**(hip, knee, etc.)**			Hepatitis C	❒	❒
Artificial Heart Valve	❒	❒	Diabetes	❒	❒	A.I.D.S.	❒	❒
***Heart Pacemaker**	❒	❒	Cancer	❒	❒	H.I.V. Positive	❒	❒
Heart Surgery.....	❒	❒	Emphysema	❒	❒	Cold Sores/Fever Blisters	❒	❒
Stroke.....	❒	❒	Chronic Cough	❒	❒	Epilepsy or Seizures	❒	❒
***Rheumatic Fever**	❒	❒	Tuberculosis	❒	❒	Tumors	❒	❒

11. Do your ankles swell during the day? .....Yes ❒ No ❒
12. Have you lost or gained more than 10 pounds in the past year? (Does not include pregnancy.) ..... Yes ❒ No ❒
13. Are you on a special diet? ..... Yes ❒ No ❒
14. Do you have or have you had any disease, condition, or problem not listed? ..... Yes ❒ No ❒
    If yes, please list: _____
15. Do you use tobacco products? ..... Yes ❒ No ❒
16. Do you use alcohol products? ..... Yes ❒ No ❒

FOR WOMEN ONLY:

17. Are you pregnant? ..... Yes ❒ No ❒ If yes, due what month?_____ Are you nursing? ..... Yes ❒ No ❒
18. Are you taking birth control pills? ..... 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 truthfully and to the best of my knowledge.

PATIENT SIGNATURE_____ **DATE**_____

PARENT OR RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT**_____

Medical Review: Reviewed by:_____ Date_____ **Medical History Update by Patient:**

Reviewed by:_____ Date_____ Initials_____ Date _____
Reviewed by:_____ Date_____ Initials_____ Date_____
Reviewed by:_____ Date_____ Initials_____ Date_____