MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐

If yes, for what reason ______________________________

Physician's Name ______________________________ Address ______________________________

Have you taken any medications or drugs during the past two years. Yes ☐ No ☐

Are you currently taking any medication, drugs or pills? Yes ☐ No ☐

1. name ____________ dosage: ______ 2. name ____________ dosage: ______ 3. name ____________ dosage: ______
4. name ____________ dosage: ______ 5. name ____________ dosage: ______ 6. name ____________ dosage: ______

Are you aware of having an allergic reaction to any medication or substance? Yes ☐ No ☐

If yes, describe ______________________________

Have you been a patient in a hospital during the past five years? Yes ☐ No ☐

If yes, please explain ______________________________

Please Indicate which of the following you have had, or have at present. Circle Y for Yes, N for No.

Condition			Condition			Condition		
Heart Attack, Surgery or Disease	Y	N	Ulcers	Y	N	Hepatitis A (Infectious) B (serum)	Y	N
Chest Pain or Angina	Y	N	Diabetes	Y	N	Venereal Disease	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N	A.I.D.S.	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	H.I.V. Positive	Y	N
High Blood Pressure	Y	N	Auto Immune Deficiency	Y	N	Cold Sores/Fever Blisters	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Blood Transfusion	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N	Hemophilia	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N	Bruise Easily	Y	N
Arthritis/Rheumatism	Y	N	Hay Fever	Y	N	Liver Disease or Jaundice	Y	N
Cortisone Medicine	Y	N	Latex Sensitivity	Y	N	Anemia	Y	N
Swollen Ankles	Y	N	Allergies or Hives	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Sinus Trouble	Y	N	Epilepsy or Seizures	Y	N
Diet (Special/Restricted)	Y	N	Radiation Therapy	Y	N	Fainting or Dizzy Spells	Y	N
Artificial Joints (Hip, Knee, etc.)	Y	N	Chemotherapy	Y	N	Nervous/Anxious	Y	N
Kidney or Bladder Trouble	Y	N	Tumors	Y	N	Psychiatric/Psychological Care	Y	N

Do you have or have you had any disease, condition, or problem not listed above? Yes ☐ No ☐

If yes, describe ______________________________

Do you use more than two pillows to sleep? Yes ☐ No ☐ Have you lost or gained more than 10 pounds in the past Year? Yes ☐ No ☐

Women: Are you pregnant? Yes ☐ - Months ______ No ☐ Nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

History Review (by Doctor):

I understand the information on both sides of this form 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. If further information is 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 change in my health or medication. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with patient. I further authorize and consent that Doctor choose and employ such assistance as deemed fit.

Patient Signature ______________________________ Date ____________

Parent/Responsible Party Signature ______________________________ Date ____________