MEDICAL HISTORY

Patient Name	
Emergency Contact Name and Number	Medical Alert

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

3. Are you taking any medication, drugs or pills now? ..... Yes No

   If yes, please list name and dosage _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No

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

6. Indicate which of the following you have had, or have at present. **Circle "yes" or "no" to each item.**

Heart (Surgery, Disease, Attack)	Yes No	Ulcers	Yes No	Hepatitis A(infectious) B(serum) C	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact Lenses	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies or Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychiatric/Psychological Care	Yes No

7. Do you use more than two pillows to sleep? ..... Yes No

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No

9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

   If yes, please list: _____

10. Have you ever been treated for chemical dependency? ..... Yes No

11. Have you ever been treated in a drug rehab? ..... Yes No

12. Women. Are you: Pregnant? Yes, ____Months No Nursing? Yes No 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 to 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 change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____