

## Medical History

1. Have been under the care of a medical doctor during the past two years? \_\_\_\_\_  
 If yes, for what? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Address \_\_\_\_\_ State \_\_\_\_\_ P/Code \_\_\_\_\_
2. Have you taken any medication or drugs in the past two years? \_\_\_\_\_
3. Are you taking any medication or drugs now? \_\_\_\_\_  
 If yes, please list name and dosage: \_\_\_\_\_
4. Are you aware of having any allergic reaction to medication? \_\_\_\_\_  
 If yes, please list: \_\_\_\_\_
5. Have you been a patient in hospital during the past five years? \_\_\_\_\_
6. Indicate which of the following you have had, or have at present.

|                          |        |                       |        |
|--------------------------|--------|-----------------------|--------|
| Heart (Surgery, Disease) | Yes/No | Ulcers                | Yes/No |
| Chest Pain               | Yes/No | Diabetes              | Yes/No |
| Congenital Heart Disease | Yes/No | Thyroid Problems      | Yes/No |
| Heart Murmur             | Yes/No | Glaucoma              | Yes/No |
| High Blood Pressure      | Yes/No | Mitral Valve Prolapse | Yes/No |
| Emphysema                | Yes/No | Chronic Cough         | Yes/No |
| Artificial Heart Valve   | Yes/No | Tuberculosis          | Yes/No |
| Heart Pacemaker          | Yes/No | Asthma                | Yes/No |
| Rheumatic Fever          | Yes/No | Hay Fever             | Yes/No |
| Arthritis                | Yes/No | Latex Sensitivity     | Yes/No |
| Cortisone Medicine       | Yes/No | Allergies or Hives    | Yes/No |
| Swollen Ankles           | Yes/No | Sinus Trouble         | Yes/No |
| Stroke                   | Yes/No | Chemotherapy          | Yes/No |
| Radiation Therapy        | Yes/No | Tumors                | Yes/No |
| Artificial Joints        | Yes/No | Venereal Disease      | Yes/No |
| Kidney trouble           | Yes/No | HIV Positive          | Yes/No |
| Hepatitis                | Yes/No | Sickle Cell Disease   | Yes/No |
| AIDS                     | Yes/No | Jaundice              | Yes/No |
| Blood Transfusion        | Yes/No | Epilepsy or Seizures  | Yes/No |
| Hemophilia               | Yes/No | Nervous/Anxious       | Yes/No |
| Liver Disease            | Yes/No | Psychological Care    | Yes/No |
| Neurological Disorder    | Yes/No | Fainting /Dizzy spell | Yes/No |

7. Do you have any disease, condition or problem not listed? \_\_\_\_\_
  8. Woman: Are you: Pregnant Yes/No Nursing? Yes/No Birth control 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.
- Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_