MEDICAL HISTORY

Patient Name: ____________________

Patient Account No: ____________________ 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 Number: ____________________
   Address: ____________________ 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
   If yes, please list: ____________________
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) _	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. 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 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 doctor of any change in my health or medication.

Patient / Guardian Signature: ____________________ Date: ____________