Patient Name/Date

MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

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

7. Do you sleep in an inclined position? .... Yes No
8. Women: Are you pregnant? Yes ____ Months No Nursing? Yes No Taking birth control pills? Yes No
9. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
   If yes, please list: ____

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 ____

History Review

Dentist Signature ____ Date ____