

Medical History

Patient Name	
Patient Account No.	Medical Alert

Physician's Name _____ Phone () _____

Have you had any medical care within the past two years? Yes No

Describe: _____

Have you taken any medication or drugs during the past two years? Yes No

Are you currently taking any medication, drugs, pills or herbal remedies including any regular dosages of aspirin? Yes No

If yes, please list name and dosage _____

Have you ever taken prescriptions medications for weight loss(diet pills)? Yes No

If yes, did you take any of the following:(circle) Fen-Phen Redux Pondimen Other

If yes to any of the above, did you have a medical exam for heart issues? Yes No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No

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

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

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

Have you lost or gained more than 10 pound in the past year? Yes No

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

If yes, please list: _____

Women: Are you pregnant or think you could be pregnant? Yes ____Months No Nursing? Yes No

Do you use birth control prescriptions? 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 _____

History Review

Dentist Signature _____ Date _____