Medical History

Patient Name____

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__________
Have you taken any medication or drugs during the past two years?...Yes/No
Are you taking any medication, drugs or pills now?...Yes/No
If yes, please list name and dosage____
Are you aware of having an allergic (or adverse reaction) to any medication or substance?.....Yes/No
If yes, please list____
Have you been a patient in the hospital during the past 5 years?..Yes/No
Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each of them.

Heart(Surgery, Disease, Attack)...Yes/No	Ulcers..Yes/No	Implants/Cosmetic Surgery.........Yes/No
Chest Pain...Yes/No	Diabetes...................................Yes/No	Hepatitis (A,B,C)............................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/Sickle Cell Disease. Yes/No
Heart Pacemaker.............................Yes/No	Tuberculosis..............................Yes/No	Bruise Easily......................................Yes/No
Rheumatic Fever..............................Yes/No	Asthma......................................Yes/No	Liver Disease/Yellow Jaundice....Yes/No
Arthritis/Rheumatism.................Yes/No	Hay Fever..................................Yes/No	Neurological Disorder..................Yes/No
Cortisone Medicine........................Yes/No	Latex Sensitive..........................Yes/No	Epilepsy orSeizures........................Yes/No
Swollen Ankles ....Yes/No	Allergies or Hives......................Yes/No	Fainting or Dizzy Spells................Yes/No
Stroke ....Yes/No	Sinus Trouble.............................Yes/No	Nervous/Anxious/Stress.................Yes/No
Diet(Special/Restricted).............Yes/No	Radiation Therapy.....................Yes/No	Psychiatric/Psychological Care.....Yes/No
Artificial Joints(hips,knee,etc.)..Yes/No	Chemotherapy............................Yes/No	Venereal Disease.........................Yes/No
Kidney Trouble...............................Yes/No	Tumors.......................................Yes/No	

Do you require an antibiotic prior to dental treatment?..Yes/No
Do you use more than two pillows to sleep?...Yes/No
Do you have or have you had any disease, conditions, or problems not listed?..Yes/No
If yes, please list____
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____

Dr._
Signature____Date__________________________