# PATIENT MEDICAL HISTORY

Date: / / Blood Pressure: /
(taken by our office)

## MEDICAL ALERTS !

Patient Name: Age: Weight: Height:

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| 1.) Have you been hospitalized in the last 5 years? Why? _____ | YES NO |
| 2.) Are you taking any medications? What? _____ | YES NO |
| 3.) Are you allergic to any medications? What? _____ | YES NO |
| 4.) Do you use Alcohol? How much a week? _____ | YES NO |
| 5.) Do you use Tobacco products? How much a day? _____ | YES NO |
| 6.) Have you had any allergies or problems with Novocaine? _____ | YES NO |
| 7.) Have you had any allergies to Latex? _____ | YES NO |
| 8.) Do you have any problem bleeding a long time if you cut yourself? _____ | YES NO |
| 9.) WOMEN: Are you pregnant,or think you may be? What month? _____ | YES NO |
| Are you taking birth control pills? _____ | YES NO |

**10.) IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS, PLEASE CIRCLE THE CORRECT RESPONSE. IF SOMEONE IN YOUR FAMILY HAS HAD THE PROBLEM, PLEASE WRITE AN "F" FOR FAMILY NEXT TO THE CORRECT RESPONSE. THANK YOU.**

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| Heart Disease or Attack | Jaundice or Liver Disease | Diabetes |
| Angina (Chest Pain) | Hepatitis A | Tuberculosis |
| Heart Murmur | Hepatitis B | Arthritis |
| Mitral Valve Prolapse | Hepatitis Non A,B | Rheumatism |
| Artificial Valve | A.I.D.S. or H.I.V. | Artificial Joints (or pins) |
| Pacemaker | Blood Transfusion | Cancer |
| High Blood Pressure | Hemophilia | Radiation Therapy |
| Low Blood Pressure | Venereal Disease | Chemotherapy |
| Swollen Ankles | Sinus Problems | Drug or Alcohol Problems |
| Anemia | Asthma | Psychiatric Treatment |
| Thyroid Disease | Hay Fever/ Allergies | Fainting or Dizziness |
| Glaucoma | Ulcers | Epilepsy |

NOTES: _____

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| 11.) Do you get shortness of breath, or chest pain walking up stairs? _____ | YES NO |
| 12.) Do you need to prop yourself up with pillows to sleep? _____ | YES NO |
| 13.) Do you have any health problems not listed? What? | YES NO |

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the doctor if there are any changes in my health, or medicines at my next appointment. I am also now aware that the doctor may take pictures for diagnosis and documentation purposes and that I give my permission for these pictures to be used for educational and scientific purposes. I authorize the insurance company to pay the dentist benefits payable to me for services rendered and authorize the use of this signature for insurance submission. I authorize release of information to the insurance company. I understand that I am financially responsible for my treatment regardless of what my insurance may or may not pay.

Patient(Parent) Signature: Dr.

| MEDICAL HISTORY UPDATE | PATIENT: |
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| Date: / / Change in Health: |
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| Change in Medications: |
| Patient Signature: Dr. |

| Date: / / Change in Health: |
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| Change in Medications: |
| Patient Signature: Dr. |

| Date: / / Change in Health: |
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| Change in Medications: |
| Patient Signature: Dr. |

| Date: / / Change in Health: |
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