

# MEDICAL HISTORY FORM

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

1. Have you been under the care of a medical doctor or hospitalized during the past two years? Yes \_\_\_ No \_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

2. Are you taking any medications, drugs or pills now or within the past two years? Yes \_\_\_ No \_\_\_

If yes, please list name and dosage \_\_\_\_\_

3. Have you ever taken prescription medications for weight loss (diet pills)? Yes \_\_\_ No \_\_\_

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

If yes, please list: \_\_\_\_\_

Heart (Surgery, Disease, Attack)	yes	no	Ulcers	yes	no	Hepatitis A	yes	no
Chest Pain	yes	no	Diabetes	yes	no	Other Hepatitis	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	Tumors	yes	no	H.I.V. Positive	yes	no
Mitral Valve Prolapse	yes	no	Transplant	yes	no	Psychiatric Care	yes	no
Artificial Heat Valve	yes	no	Emphysema	yes	no	Cold Sores/Fever Blisters	yes	no
Heart Pacemaker	yes	no	Chronic Cough	yes	no	Blood Transfusion	yes	no
Rheumatic Fever	yes	no	Tuberculosis	yes	no	Hemophilia	yes	no
Arthritis/Rheumatism	yes	no	Asthma	yes	no	Sickle Cell Disease	yes	no
Cortisone Medicine	yes	no	Hay Fever	yes	no	G6PD	yes	no
Swollen Ankles	yes	no	Latex Sensitivity	yes	no	Liver Disease	yes	no
Stroke	yes	no	Allergies or Hives	yes	no	Yellow Jaundice	yes	no
Diet (Special/Restricted)	yes	no	Sinus Trouble	yes	no	Neurological Disorders	yes	no
Artificial Joints (hip, knee, etc.)	yes	no	Radiation Therapy	yes	no	Epilepsy or Seizures	yes	no
Kidney Trouble	yes	no	Chemotherapy	yes	no	Fainting or Dizzy Spells	yes	no

Please mention any disease, condition, or problem not listed above: \_\_\_\_\_

**Women:** Are you: **Pregnant?** No \_\_\_ Yes \_\_\_ Months \_\_\_ **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 / 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. / will notify the dentist of change in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_