

Patient Name

MEDICAL HISTORY

Patient Account No.

Medical Alert

1. Physician's Name _____ Phone () _____
Have you had any medical care within the past two years? ☐ Yes ☐ No
Describe _____
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ☐ Yes ☐ No
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ Yes ☐ No
If yes, did you take any of the following? (Check if yes) ☐ Fen-Phen ☐ Pondimin ☐ Redux ☐ Other
If yes to any of the above, did you have a medical exam for heart issues? ☐ Yes ☐ No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☐ No
If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.
- | | | |
|---|---|--|
| Heart (Surgery, Disease, Attack) <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters ... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High/Low Blood Pressure .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact Lenses <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve/
Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease/Yellow
Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles. <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever/Allergy/Hives ... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (Special/Restricted) ... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological
Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints
(Hip, Knee, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Tumors <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Hepatitis A, B, C .. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | |
9. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No
10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
11. Women: Are you pregnant or think you could be pregnant? ☐ Yes _____ Months ☐ No Nursing? ☐ Yes ☐ No
12. Do you use birth control prescriptions? ☐ Yes ☐ No
13. Are you currently under the care of a Physician ☒ Yes ☐ No
14. If yes, Please Provide us with Dr's Name and Phone Number

I understand the above information in 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 _____

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History Review

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