MEDICAL HISTORY

Patient ID#

Patient Name:	Medical Alert (Office Use Only)

Circle

1. Have you been under the care of a medical doctor for a specific condition during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's name _____ Phone: (____) _____
   (first) (initial) (last)
2. Are you taking any medication, drugs, or pills now (including herbal)? ..... Yes No
   If yes, please list name and dosage _____
3. Have you taken any medication or drugs during the past two years not listed above? ..... Yes No
   If yes, please list _____
   _____
4. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ..... Yes No
   If yes, please list _____
5. Have you been in the hospital in the past five years? ..... Yes No
   If yes, please indicate reason _____
6. 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	Ulcers ..... Yes No	Hepatitis A (Infectious) B (Serum) C .... Yes No
Chest Pain ..... Yes No	Diabetes ..... Yes No	Liver Disease ..... Yes No
Congenital Heart Disease ..... Yes No	Thyroid Problems ..... Yes No	Yellow Jaundice ..... Yes No
Heart Murmur ..... Yes No	Glaucoma ..... Yes No	Venereal Disease ..... Yes No
High Blood Pressure ..... Yes No	Emphysema ..... Yes No	A.I.D.S. ..... Yes No
Mitral Valve Prolapse ..... Yes No	Chronic Cough ..... Yes No	H.I.V. Positive ..... Yes No
Artificial Heart Valve ..... Yes No	Tuberculosis ..... Yes No	Cold Sores / Fever Blisters ..... Yes No
Heart Pacemaker ..... Yes No	Asthma ..... Yes No	Blood Transfusion ..... Yes No
Rheumatic Fever ..... Yes No	Hay Fever ..... Yes No	Hemophilia ..... Yes No
Stroke ..... Yes No	Latex Sensitivity ..... Yes No	Sickle Cell Disease ..... Yes No
Swollen Ankles ..... Yes No	Allergies or Hives ..... Yes No	Bruise Easily ..... Yes No
Arthritis/Rheumatism ..... Yes No	Sinus Trouble ..... Yes No	Neurological Disorders ..... Yes No
Cortisone Medication ..... Yes No	Radiation Therapy ..... Yes No	Epilepsy or Seizures ..... Yes No
Diet (Special) Restricted ..... Yes No	Chemotherapy ..... Yes No	Fainting or Dizzy Spells ..... Yes No
Artificial Joints (hip, knee, etc.) ..... Yes No	Tumors ..... Yes No	Nervous / Anxious ..... Yes No
Kidney Trouble ..... Yes No		Psychiatric / Psychological Care ..... Yes No

7. Do you use more than two pillows to sleep ..... Yes No
8. Have you lost or gained more than 10 pounds in the last year? ..... Yes No
9. Do you have, or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. Do you smoke? ..... Yes No
11. Do you chew tobacco? ..... Yes No
12. Do you require a hearing aid(s)? ..... Yes No
13. **WOMEN:** Are you: **Pregnant?** Yes No _____ 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, efficient manner. 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 dentist or his staff of any change in my health or medication.

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information.

Patient / Guardian Signature _____ Date _____

History Review

Dentist's Signature _____