Medical History Information

Patient Name _____

1. Describe your current dental problem(s)? _____

_____

2. Are you having pain or discomfort at this time? ☐Yes ☐No
3. Have you been a patient in the hospital during the past two years? ☐Yes ☐No
4. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No

   Physician's Name _____ Phone Number _____

   Address _____

5. Have you taken any medication or drugs in the past two years? ☐Yes ☐No
6. **Are you now taking any medications or drugs? (includes medication for pain, recreational drugs, and hormones)** ☐Yes ☐No

   If yes, please list: _____

7. **Are you currently taking any type of Herbal Supplements?** ☐Yes ☐No

   If yes, please list: _____

8. **Are you sensitive or allergic to any medication or anesthetics?** ☐Yes ☐No

   If yes, please list: _____

9. Have you ever taken the diet drug Phen-Phen? ☐Yes ☐No
10. Indicate which of the following you have had or have at the present. Check "yes" or "no" for each item.

Heart Failure	☐Yes	☐No	*Artificial Joints (hip, knee, etc.)	☐Yes	☐No	Hepatitis B (serum)	☐Yes	☐No
Heart Disease or Attack	☐Yes	☐No	Kidney Trouble	☐Yes	☐No	Hepatitis C	☐Yes	☐No
Angina Pectoris	☐Yes	☐No	Ulcers	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Congenital Heart Disease	☐Yes	☐No	Diabetes	☐Yes	☐No	A.I.D.S.	☐Yes	☐No
*Heart Murmur	☐Yes	☐No	Thyroid Problems	☐Yes	☐No	H.I.V. Positive	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Glaucoma	☐Yes	☐No	Cold Sores/Fever Blisters	☐Yes	☐No
Arteriosclerosis	☐Yes	☐No	Cancer	☐Yes	☐No	Hemophilia	☐Yes	☐No
*Mitral Valve Prolapse	☐Yes	☐No	Emphysema	☐Yes	☐No	Anemia	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	Chronic Cough	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
*Heart Pacemaker	☐Yes	☐No	Tuberculosis	☐Yes	☐No	Bruise Easily	☐Yes	☐No
Heart Surgery	☐Yes	☐No	Asthma	☐Yes	☐No	Liver Disease	☐Yes	☐No
*Rheumatic Fever	☐Yes	☐No	Hey Fever	☐Yes	☐No	Yellow Jaundice	☐Yes	☐No
Arthritis	☐Yes	☐No	Allergies or Hives	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No
Rheumatism	☐Yes	☐No	Sinus Trouble	☐Yes	☐No	Fainting or Dizzy Spells	☐Yes	☐No
Cortisone Medicine	☐Yes	☐No	Radiation Therapy	☐Yes	☐No	Nervousness	☐Yes	☐No
Drug Addiction	☐Yes	☐No	Chemotherapy	☐Yes	☐No	Tumors	☐Yes	☐No
Stroke	☐Yes	☐No	Hepatitis A (infectious)	☐Yes	☐No	Developmentally Disabled	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No	Breathing Problems	☐Yes	☐No	Frequent Diarrhea	☐Yes	☐No
Blood Disease	☐Yes	☐No	Shortness of Breath	☐Yes	☐No	Excessive Thirst	☐Yes	☐No
Hypoglycemia	☐Yes	☐No	Pain in Jaw Joints	☐Yes	☐No	Alzheimer's Disease	☐Yes	☐No

11. Do your ankles swell during the day? ☐Yes ☐No
12. Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No
13. Are you on a special diet? ☐Yes ☐No
14. Do you have or have you had any disease, condition, or problem not listed? ☐Yes ☐No

    If yes, please list: _____

15. Do you use tobacco products? ☐Yes ☐No
16. Do you use alcohol products? ☐Yes ☐No

FOR WOMEN ONLY:

17. Are you pregnant? ☐Yes ☐No If yes, what month? _____ Are you nursing? ☐Yes ☐No
18. Are you 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 truthfully and to the best of my knowledge.

PATIENT SIGNATURE _____ **DATE** _____

PARENT OR RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT** _____

Medical Review: Reviewed by: _____ Date _____
Reviewed by: _____ Date _____
Reviewed by: _____ Date _____
Reviewed by: _____ Date _____
Reviewed by: _____ Date _____
Reviewed by: _____ Date _____

Medical History Update by Patient: Initials _____ Date _____
Initials _____ Date _____
Initials _____ Date _____
Initials _____ Date _____
Initials _____ Date _____
Initials _____ Date _____