MEDICAL HISTORY

Patient Name:	Medical Alert:

1. Have you been under the care of a medical doctor during the past two years?……..…….…… Yes No
   If yes, for what? _____
2. Physician's Name: _____ Phone: _____
   Address: _____ City: _____ State: _____ Zip: _____
3. Have you taken any medication/drugs in the past 2 years?…….……..…..…... Yes No
4. Are you taking any medication, drugs or pills now? (Please list in box below)……..……..…. Yes No
5. Are you taking Aspirin or Vitamin E daily? Name & dosage: _____ Yes No
6. Have you ever stayed overnight in the hospital? If "yes" please list when and what for: _____ Yes No
   _____

7. *Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item:*

AIDS/HIV……..……	Yes	No	Diabetes……..….	Yes	No	Nervous/Anxious…….	Yes	No
Allergies or Hives…….……	Yes	No	Diet (Special/Restricted)……..….	Yes	No	Neurological Disorders……	Yes	No
Anemia……..……	Yes	No	Emphysema……..……	Yes	No	Osteoporosis……..…	Yes	No
Artificial Heart Valves……	Yes	No	Epilepsy or Seizures……..……	Yes	No	Psychiatric/Psychological Care…	Yes	No
Artificial Joints (Hip, Knee, etc.)..	Yes	No	Fainting or dizziness……..……	Yes	No	Radiation Therapy……	Yes	No
Arthritis/Rheumatism…….….	Yes	No	Glaucoma……..……	Yes	No	Rheumatic Fever……..…	Yes	No
Asthma……..….	Yes	No	Heart (Surgery, Disease, Attack)…	Yes	No	Sickle Cell Disease……	Yes	No
Blood Transfusion……..….	Yes	No	Heart Murmur……..……	Yes	No	Sinus Trouble……	Yes	No
Bruise Easily……..……..	Yes	No	Heart Pacemaker……..……	Yes	No	Stroke……..…	Yes	No
Cancer: _____	Yes	No	Hemophilia……	Yes	No	Thyroid Problems……..……	Yes	No
Chemotherapy……	Yes	No	Hepatitis Type:_____	Yes	No	Tuberculosis…….	Yes	No
Chest Pain……..……	Yes	No	High Blood Pressure…….	Yes	No	Tumors…….	Yes	No
Chronic Cough…….…..….	Yes	No	Kidney Trouble……..…...	Yes	No	Ulcers……..……..	Yes	No
Congenital Heart Disease…..….	Yes	No	Liver Disease……	Yes	No	Venereal Disease……..…	Yes	No
Cortisone Medicine……	Yes	No	Mitral Valve Prolapse……..….	Yes	No	Yellow Jaundice……	Yes	No

8. Do you use more than 2 pillows to sleep?..…….…..…. Yes No
9. Do you have or have you had any disease, condition, or problem not listed? _____ Yes No
10. Have you lost or gained more than 10 pounds in the past year?……..…… Yes No

Women: Are you: Pregnant? Yes, _____ Months No **Nursing?** Yes No **Taking Birth Control pills?** Yes No

MEDICATIONS	ALLERGIES
List any Medications and correlating diagnosis: _____ _____ _____ _____	❑ Aspirin ❑ Barbiturates (sleeping pills) ❑ Codeine ❑ Iodine ❑ Latex ❑ Local Anesthetic ❑ Penicillin ❑ Sulfa ❑ Other_____ _____ _____

In the event that I am unable to make decisions about my healthcare, I give _____, (Relationship: _____) permission to make decisions for me. (Healthcare Surrogate)
I understand the above information is 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

Initial	Date	Initial	Date	Initial	Date	Initial	Date

Dentist Signature: _____ Date: _____