

MEDICAL HISTORY

Patient Name _____
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
If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes No
If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Yes No
If yes, please list name and dosage _____
5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? Yes No
7. 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 B C (circle) ... | Yes | No |
| Chest Pain | Yes | No | Diabetes | Yes | No | Venereal Disease | Yes | No |
| Congenital Heart Disease | Yes | No | Thyroid Problems | Yes | No | A.I.D.S./H.I.V. Positive | Yes | No |
| Heart Murmur | Yes | No | Glaucoma | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| High/Low Blood Pressure | Yes | No | Contact lenses | Yes | No | Blood Transfusion | Yes | No |
| Mitral Valve Prolapse | Yes | No | Emphysema | Yes | No | Hemophilia | Yes | No |
| Artificial Heart Valve/Pacemaker | Yes | No | Chronic Cough | Yes | No | Sickle Cell Disease | Yes | No |
| Rheumatic Fever | Yes | No | Tuberculosis | Yes | No | Bruise Easily | Yes | No |
| Arthritis/Rheumatism | Yes | No | Asthma | Yes | No | Liver Disease/Yellow Jaundice .. | Yes | No |
| Cortisone Medicine | Yes | No | Hay Fever/Allergy/Hives | Yes | No | Neurological Disorders | Yes | No |
| Swollen Ankles | Yes | No | Latex Sensitivity | Yes | No | Epilepsy or Seizures | Yes | No |
| Stroke | Yes | No | Sinus Trouble | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Diet (Special/Restricted) | Yes | No | Radiation Therapy | Yes | No | Nervous/Anxious | Yes | No |
| Artificial Joints (hip, knee, etc.) ... | Yes | No | Chemotherapy | Yes | No | Psychiatric/Psychological Care.. | Yes | No |
| Kidney Trouble | Yes | No | Tumors | Yes | No | Cancer | Yes | No |
8. Have you lost or gained more than 10 pounds in the past 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. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? 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 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 _____