

PATIENT NAME \_\_\_\_\_

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Have you taken any medications or drugs during the past two years? Yes No

3. Are you taking any medications, drugs, or pills now? Yes No

If yes, please list name and dosage: \_\_\_\_\_

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 a patient in the hospital during the past five years? Yes No

6. Indicate which of the following you have had or have at present. Please check all that apply.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart (surgery,disease,attack)   | <input type="checkbox"/> Ulcers            | <input type="checkbox"/> Hepatitis A or B         |
| <input type="checkbox"/> Chest Pain                       | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Venereal Disease         |
| <input type="checkbox"/> Congenital Heart Disease         | <input type="checkbox"/> Thyroid           | <input type="checkbox"/> A.I.D.S.                 |
| <input type="checkbox"/> Heart Murmur                     | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> H.I.V. Positive          |
| <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Contacts          | <input type="checkbox"/> Cold Sores               |
| <input type="checkbox"/> Mitral Valve Prolapse            | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Blood Transfusion        |
| <input type="checkbox"/> Artificial Heart Valve           | <input type="checkbox"/> Chronic Cough     | <input type="checkbox"/> Hemophilia               |
| <input type="checkbox"/> Heart Pacemaker                  | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Sickle Cell Disease      |
| <input type="checkbox"/> Rheumatic Fever                  | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Bruise easily            |
| <input type="checkbox"/> Arthritis/Rheumatism             | <input type="checkbox"/> Hay Fever         | <input type="checkbox"/> Liver Disease            |
| <input type="checkbox"/> Cortisone Medicine               | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Yellow Jaundice          |
| <input type="checkbox"/> Swollen ankles                   | <input type="checkbox"/> Allergies / Hives | <input type="checkbox"/> Neurological Disorder    |
| <input type="checkbox"/> Stroke                           | <input type="checkbox"/> Sinus Trouble     | <input type="checkbox"/> Epilepsy or Seizures     |
| <input type="checkbox"/> Diet (special or restricted)     | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Fainting or Dizzy spells |
| <input type="checkbox"/> Artificial Joints (hip,knee,etc) | <input type="checkbox"/> Chemotherapy      | <input type="checkbox"/> Nervous / Anxious        |
| <input type="checkbox"/> Kidney trouble                   | <input type="checkbox"/> Tumors            | <input type="checkbox"/> Psychological Disorders  |

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. Women. Are you pregnant? Yes, \_\_\_ months No 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 and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you may 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 changes in my health or medication.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

History Review	Medical Alert
Doctor Signature: _____	Date: _____