

MEDICAL HISTORY

	Allergies
Patient Name	Medical Alert

1. Have you been under the care of a physician during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
2. What medications or drugs are you currently taking, including aspirin, over-the-counter, herbal medicines?
 Please list name and dosage _____
3. Have you ever taken any prescription drugs for weight loss, including Redex (dexfenfluramine); Pondimen (fenfluramine); and Fen-Phen (fenfluramine-phentermine)? Yes No
 If yes to the above, did you have a medical exam for heart issues? Yes No
4. Have you had 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. Circle "yes" or "no" to each item.

A.I.D.S.....	Yes No	Diet (Special/Restricted)	Yes No	Mitral Valve Prolapse	Yes No
Allergies or Hives	Yes No	Emphysema	Yes No	Nervous/Anxious	Yes No
Artificial Heart Valve	Yes No	Epilepsy or Seizures	Yes No	Neurological Disorders	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Fainting or Dizzy Spells.....	Yes No	Psychiatric/Psychological Care ...	Yes No
Arthritis / Rheumatism.....	Yes No	Glaucoma	Yes No	Radiation Therapy.....	Yes No
Asthma	Yes No	Hay Fever.....	Yes No	Rheumatic Fever.....	Yes No
Blood Transfusion	Yes No	Heart Murmur	Yes No	Sickle Cell Disease	Yes No
Bruise Easily	Yes No	Heart Pacemaker	Yes No	Sinus Trouble	Yes No
Chemotherapy.....	Yes No	Heart (Surgery, Disease, Attack)	Yes No	Stroke.....	Yes No
Chest Pain.....	Yes No	Hemophilia	Yes No	Swollen Ankles.....	Yes No
Chronic Cough	Yes No	Hepatitis A B C (circle).....	Yes No	Thyroid Problems	Yes No
Cold Sores / Fever Blisters	Yes No	High Blood Pressure	Yes No	Tuberculosis.....	Yes No
Congenital Heart Disease	Yes No	H.I.V. Positive.....	Yes No	Tumors	Yes No
Contact lenses	Yes No	Kidney Trouble	Yes No	Ulcers	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Venereal Disease.....	Yes No
Diabetes	Yes No	Liver Disease	Yes No	Yellow Jaundice	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 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 may be pregnant? Yes, _____ Months No Nursing? Yes No
11. Women: Do you use birth control medications? Yes No

I understand the above information is required to provide me with dental care in a safe and efficient manner. All questions have been answered to the best of my knowledge. You have my permission to ask the respective health care provider or agency to release any additional patient information, should the information be needed. I will notify the dentist of any changes in my health condition.

Patient/Guardian Signature _____ Date _____

History Review	
Dentist Signature _____	Date _____