

MEDICAL HISTORY

Patient Name
Patient Account No.
Medical Alert

Please complete form. All information is confidential.

- 1. Have you been under the care of a medical doctor during the past two years?
2. Have you taken any medication or drugs during the past two years?
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin?
4. Have you ever taken prescription medications for weight loss (diet pills)?
5. Are you aware of having an allergic, (or adverse) reaction to any medication or substance?
6. Have you been a patient in the hospital during the past five years?
7. Indicate which of the following you have had, or have a present.

Table with 8 columns: Condition, Yes, No, Condition, Yes, No, Condition, Yes, No. Rows include Heart (Surgery, Disease, Attack), Chest Pain, Congenital Heart Disease, Heart Murmur, High Blood Pressure, Mitral Valve Prolapse, Artificial Heart Valve, Heart Pacemaker, Rheumatic Fever, Arthritis/Rheumatism, Cortisone Medicine, Swollen Ankles, Stroke, Diet (Special/Restricted), Artificial Joints (hips, knees etc), Kidney Trouble, Ulcers, Diabetes, Thyroid Problems, Glaucoma, Contact Lenses, Emphysema, Chronic Cough, Tuberculosis, Asthma, Hay Fever, Latex Sensitivity, Allergies or Hives, Sinus Trouble, Radiation Therapy, Chemotherapy, Tumors, Hepatitis A (infectious) B (serum), Venereal Disease, A.I.D.S, H.I.V. Positive, Cold Sores/Fever Blisters, Blood Transfusion, Hemophilia, Sickle Cell Disease, Bruise Easily, Liver Disease, Yellow Jaundice, Neurological Disorders, Epilepsy or Seizures, Fainting or Dizzy Spells, Nervous/Anxious, Psychiatric/Psychological Care.

- 8. Do you use more than two pillows to sleep?
9. Have you lost or gained more than 10 pounds in the past year?
10. Do you have or have you had any disease, condition, or problem not listed?
11. 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 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 change in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_