Medical History

Are you under a physician's care now? Why_____Who?_____Phone_____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck?_____ Yes No

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What?_____ Yes No

Are you on a special diet? Discuss_____ Yes No

Are you allergic to any medications or substances? Please check box below_____ Yes No

☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Codeine ☐ Metal ☐ Latex Rubber ☐ Other_____ Yes No

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss_____ Yes No

Do you have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
***If yes to any of the starred conditions, please call prior to your appointment…premedication or changes in medication may be required.**

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Defect *	☐	☐	Lung Disease	☐	☐	Nervousness	☐	☐	Renal Dialysis	☐	☐
Mitral Valve Prolapse*	☐	☐	Breathing Problem	☐	☐	Psychiatric Care	☐	☐	Thyroid Disease	☐	☐
Artificial Heart Valve*	☐	☐	Shortness of Breath	☐	☐	Has taken fen-phen	☐	☐	Parathyroid Disease	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Osteonecrosis of Jaw	☐	☐	Arthritis/Gout	☐	☐
Coronary Stent*	☐	☐	Asthma	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐
Bacterial Endocarditis*	☐	☐	Hay Fever	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐
Rheumatic Fever*	☐	☐	Sinus Trouble	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐
Artificial Joint*	☐	☐	Bloody Sputum	☐	☐	Frequent Diarrhea	☐	☐	Sexually Transmitted Infection	☐	☐
Needs Premedication*	☐	☐	Tumors or Growth	☐	☐	Diabetes	☐	☐	Herpes	☐	☐
Stroke	☐	☐	Cancer	☐	☐	Excessive Thirst	☐	☐	Cold Sores	☐	☐
High Blood Pressure	☐	☐	Chemotherapy	☐	☐	Hypoglycemia	☐	☐	Sleep Apnea	☐	☐
Low Blood Pressure	☐	☐	Radiation	☐	☐	Liver Disease	☐	☐	Glaucoma	☐	☐
Unexplained Fever	☐	☐	Osteoporosis	☐	☐	Hepatitis	☐	☐	Drug/Alcohol Addiction	☐	☐
Blood Disease/Defect	☐	☐	Fosamax, Actonel, Boniva	☐	☐	HIV/AIDS	☐	☐	Hives or Rash	☐	☐
Bruise Easily	☐	☐	Epilepsy or Seizures	☐	☐	Protease Inhibitor	☐	☐			
Recent Blood Transfusion	☐	☐	Fainting or Dizziness	☐	☐	Yellow Jaundice	☐	☐	Allergies (Medicines)	☐	☐
Swelling of Limbs	☐	☐	Alzheimer's Disease	☐	☐	Kidney Problems	☐	☐	Allergies (Pollen/Dust)	☐	☐

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____ _____ _____

PATIENT SIGNATURE (PARENT OR GUARDIAN) Print Name Date

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	NONE ☐	_____	___	____	Dr. _____
_____	_____	NONE ☐	_____	___	____	Dr. _____
_____	_____	NONE ☐	_____	___	____	Dr. _____
_____	_____	NONE ☐	_____	___	____	Dr. _____
_____	_____	NONE ☐	_____	___	____	Dr. _____
_____	_____	NONE ☐	_____	___	____	Dr. _____