

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 *	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Has taken fen-phen	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Osteonecrosis of Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Stent*	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Endocarditis*	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infection	<input type="checkbox"/>	<input type="checkbox"/>
Needs Premedication*	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growth	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Fever	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease/Defect	<input type="checkbox"/>	<input type="checkbox"/>	Fosamax, Actonel, Boniva	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Protease Inhibitor	<input type="checkbox"/>	<input type="checkbox"/>			
Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>

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	NONE	PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	<input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	_____	Dr. _____