

Patient Name
Patient Account No.

# Medical History

Medical Alert
---------------

Welcome! So that we may provide you with the best possible care, please complete both the dental and medical history forms. All information is completely confidential.

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 \_\_\_\_\_

Have you taken any medication or drugs during the past two years? ..... Yes  No  
 Are you taking any medication, drugs, or pills now? ..... Yes  No  
 If yes, please list name and dosage: \_\_\_\_\_  
 Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes  No  
 If yes, please list: \_\_\_\_\_  
 Have you been a patient in the hospital during the past five years? ..... Yes  No

Indicate which of the following you have had, or have at present. Please circle "Yes" or "No" for each item:

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

Do you use more than two pillows to sleep? ..... Yes  No  
 Have you lost or gained more than 10 pounds in the past year? ..... Yes  No  
 Do you have or have you had any disease, condition, or problem not listed? ..... Yes  No  
 If yes, please list: \_\_\_\_\_

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 any change in my health or medication.

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

History Review:

  
  
  
  
  
  
  
  
  
  

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_