MEDICAL HISTORY

Patient Name _____ Birth date _____

Are you currently under medical care? ☐ Yes ☐ No If yes, reason _____

Physician's Name and Location _____

In the past 3 years have you been hospitalized or had a major operation? ☐ Yes ☐ No Reason _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No Explain _____

Do you use tobacco? ☐ Yes ☐ No

Women: Are you ☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Metals ☐ Latex ☐ Local Anesthetics ☐ Other _____

List Current Medications: Purpose

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Check any of the following which you have had or presently have: *** MAY REQUIRE MEDICATION**

☐ AIDS/HIV Positive	☐ Bruise Easily	☐ Fainting/Dizziness	☐ Abnormal Blood Pressure	☐ Scarlet Fever
☐ Allergies/Sinus Problems	☐ Cancer	☐ Glaucoma	☐ Irregular Heartbeat	☐ Shingles
☐ Alzheimer's Disease	☐ Cold Sores	☐ Heart Attack	☐ Kidney Problems	☐ Sickle Cell Anemia
☐ Anemia	☐ Congenital Heart Disorder	☐ **Heart Murmur***	☐ Leukemia	☐ Spina Bifida
☐ Angina	☐ Diabetes	☐ Heart Pacemaker	☐ Liver Disease	☐ Stomach/Intestinal Disease
☐ Arthritis/Rheumatism	☐ Drug Addiction	☐ Heart Stent	☐ Lung Disease	☐ Stroke
☐ **Artificial Heart Valve***	☐ Eating Disorders	☐ Heart Disease	☐ **Mitral Valve Prolapse***	☐ Thyroid Disease
☐ **Artificial Joint***	☐ Emphysema	☐ Hemophilia	☐ Psychiatric Care	☐ Tuberculosis
☐ Asthma	☐ Epilepsy/Seizures	☐ Hepatitis	☐ Renal Dialysis	☐ Tumors/Growths
☐ Blood Disease	☐ Excessive Bleeding	☐ Herpes	☐ **Rheumatic Fever***	☐ Venereal Disease

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, explain _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

Date:	Initials:	BP:	Date:	Initials:	BP:	Date:	Initials:	BP:
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____