

Patient Name: _____

MEDICAL HISTORY

1. **When was your last complete physical exam?** _____ Last Blood Pressure Level ____ / ____

Your Physician's Name _____ Phone # _____

Have you had any medical care within the past two years? **Yes No**

If Yes, Please Describe _____

2. **Are you currently taking any medication? Yes No**, if yes please list _____

3. Have you taken any medication or drugs during past two years? **Yes No**, If yes, What? _____

4. Do you routinely take health related or preventive substances such as **Aspirin**, Garlic, Vitamin, Herbals, etc? **Yes No**

If yes, please list _____

5. Have you ever taken prescription medication for weight loss (Diet Pills) such as Fen-Fen, Pondimen, Redux, and Other _____ . If yes, did you have a medical exam for heart tissue? **Yes No**

6. Have you ever taken medication for prevention of bone loss such as Fosamax, Actonel, Boniva, or other? **Yes No**

7. **Have you been hospitalized during past five years?** **Yes No**

8. Do you have to be pre-medicated with Antibiotic Prophylaxis before your dental treatments? **Yes No**

9. Have you experienced any of the following? (Please circle Yes or No):

Chest pain (angina)	Yes	No	Blood in stool	Yes	No	Frequent vomiting	Yes	No
Fainting spells	Yes	No	Diarrhea /constipation	Yes	No	Jaundice	Yes	No
Fever	Yes	No	Frequent urination	Yes	No	Dry mouth	Yes	No
Night sweats	Yes	No	Difficulty urinating	Yes	No	Excessive thirst	Yes	No
Persistent cough	Yes	No	ringing in ears	Yes	No	Difficulty swallowing	Yes	No
Coughing up blood	Yes	No	Headaches	Yes	No	Swollen ankles	Yes	No
Bleeding problem	Yes	No	Dizziness	Yes	No	Joint pain or stiffness	Yes	No
Blood in urine	Yes	No	Blurred vision	Yes	No	Shortness of breath	Yes	No
Significant weight loss	Yes	No	Bruise easily	Yes	No	Sinus problems	Yes	No

10. Have you had or do you have any of the following? (Please circle Yes or No):

Heart disease.....	Yes	No	Ulcers.....	Yes	No	Hepatitis A.....	Yes	No
Heart attack.....	Yes	No	Diabetes.....	Yes	No	Hepatitis B or C.....	Yes	No
Heart surgery.....	Yes	No	Thyroid problems.....	Yes	No	AIDS/ HIV.....	Yes	No
Heart murmur.....	Yes	No	Glaucoma.....	Yes	No	Hemophilia.....	Yes	No
High blood pressure	Yes	No	Kidney trouble.....	Yes	No	Sickle cell disease.....	Yes	No
Mitral valve prolapsed.....	Yes	No	Liver disease.....	Yes	No	Venereal disease.....	Yes	No
Artificial heart valve.....	Yes	No	Emphysema.....	Yes	No	Skin disease.....	Yes	No
Rheumatic fever.....	Yes	No	Asthma.....	Yes	No	Neurological disorders....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Hay fever/allergy/hives...	Yes	No	Epilepsy or seizures.....	Yes	No
Cortisone medicine.....	Yes	No	Tumors or cancer.....	Yes	No	Nervous/anxious.....	Yes	No
Stroke.....	Yes	No	Chemo/Radiation therapy	Yes	No	Psychiatric care.....	Yes	No
Artificial joints	Yes	No	Tuberculosis.....	Yes	No	Psychological care.....	Yes	No

(Please complete and sign the other side)

11. Are you allergic to or have you had a reaction to any of the following? (please circle)

Aspirin Codeine Valium Penicillin Local Anesthetic Latex Food Metal
Darvon Demerol Vicodin Erythromycin Nitrous Oxide Percodan tetracycline

Others: _____

12. Do you currently use any recreational drugs? **Yes No**

13. Have you ever used any recreational drugs? **Yes No**, if yes when did you stop using? _____

14. Do you have or have had any disease, condition, or problem not listed in this form? **Yes No**
If yes, please list: _____

15. Do you smoke cigarette or use tobacco in any form? **Yes No**, if yes are you interested in quitting? **Yes No**

16. Do you drink alcohol? **Yes No**, if yes # of drinks per week? _____

17. **Woman:**

Are you pregnant or think you are pregnant? **Yes No** if yes what month? _____ Nursing? **Yes No**

Are you using birth control prescriptions? **Yes No**

Are you under any Hormone Therapy? **Yes No**

Note: I certify that I have read and understand this form. I have answered all of the questions to the best of my knowledge. I understand the above information is necessary for having a safe and efficient dental care. If any further health history information is needed, you have my permission to ask the respective health care provider or agency for a release of such information to you. It is my responsibility to notify the dentist in this facility of any change in my health or medication. Further, I will not hold my dentist or any other member of staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) X _____, Date _____

History Review by the Dentist:	ASA. I II III IV
	BP ____ / ____
	HR ____ / Min.
	Date: _____
Dentist Signature X _____	

MEDICAL HISTORY UPDATES

I have reviewed my Medical History and confirm that it accurately states past and present condition.

DATE	PATIENT SIGNATURE	CHANGES TO MEDICAL HISTORY	DENTIST INITIAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____