MEDICAL HISTORY INFORMATION

Patients Name: _____

Name of Physician: _____ Phone: (____) _____

Preferred Pharmacy: _____ Phone: (____) _____

Do you have or have ever had any of the following? Please check those that apply:

[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Breathing Problems
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Diabetes
[ ] Epilepsy or Seizures
[ ] Excessive Thirst
[ ] Fainting or Dizziness
[ ] Fever Blisters/Cold Sores
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Disorder (Congenital)*
[ ] Heart Infection*
[ ] Heart Murmur*
[ ] Heart Pace Maker*
[ ] Heart Surgery*
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV*/AIDS
[ ] Kidney Problems
[ ] Liver Problems
[ ] Mental Disorders
[ ] Mitral Valve Prolapse*
[ ] Osteoporosis
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Rheumatism
[ ] Sickle Cell Disease
[ ] Sinus Problems
[ ] Stroke
[ ] Surgical Shunt*
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease
[ ] Yellow Jaundice

* This condition may require antibiotic pre-medication for certain dental procedures.

Yes No

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____

[ ] [ ] Are you now under the care of a physician?
If yes, explain: _____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____

[ ] [ ] Are you taking any medications or herbals?
If yes, list: _____

[ ] [ ] Are you allergic to any medications or substances?
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other _____

[ ] [ ] Have you used tobacco?
If yes, explain: _____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, I have given an accurate report of my physical and mental health history. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

_____

Signature of patient, parent or guardian Date