Medical History

Patient's Name _____ Date _____

Medical Doctor's Name _____ Phone _____
Are you under a doctor's care now? **YES** **NO** Why? _____
Do we have your permission to contact her/him regarding your care? **YES** **NO**
Have you been hospitalized during the past two years? **YES** **NO** For what? _____

_____

Are you taking medications, pills or drugs? **YES** **NO** List drug(s) & reason for taking;

_____

_____

Do you require antibiotic pre-medication for your dental work? **YES** **NO**
What for? _____
Are you allergic to any medications or substances? **YES** **NO** List: _____
☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Latex Rubber ☐ Metals ☐ Penicillin/Antibiotics ☐ Sulfa Drugs
Women: Are you pregnant or trying to get pregnant? **YES** **NO** How far along? _____
Are you nursing? **YES** **NO** Are you taking birth control pills? **YES** **NO**

Please CHECK if you have ever had any of the following:

☐ Allergies	☐ Dizziness	☐ Herpes	☐ Respiratory Problems
☐ Anemia	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ HIV+/AIDS	☐ Rheumatism
☐ Artificial Heart Valve	☐ Epilepsy/Convulsions	☐ Hives/Skin Rash	☐ Scarlet Fever
☐ Artificial Hip/Joints	☐ Excessive Thirst	☐ Hypoglycemia	☐ Seizures
☐ Arthritis/Gout	☐ Fainting	☐ Irregular Heart Beat	☐ Sexually Transmitted Disease
☐ Asthma	☐ Fever Blisters	☐ Kidney Disease	☐ Sickle Cell Anemia
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Sinus Trouble
☐ Blood Transfusion	☐ Glaucoma	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Hay Fever	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Heart Attack	☐ Lung Disease	☐ Tattoos/Body Piercing
☐ Chemotherapy/Radiation	☐ Heart Disease	☐ Mitral Valve Prolaspe	☐ Thyroid Disease
☐ Chest Pain	☐ Heart Murmur	☐ Nervousness	☐ TMD/TMJ (Jaw Pain)
☐ Circulatory Problems	☐ Heart Pacemaker	☐ Osteoporosis	☐ Tobacco Habit
☐ Cold Sores	☐ Heart Surgery	☐ Pain in Jaw Joints	☐ Tuberculosis (TB)
☐ Congenital Heart Lesion	☐ Hemophilia	☐ Parathyroid Disease	☐ Ulcers
☐ Cortisone Medicine	☐ Hepatitis A ☐ or B ☐	☐ Psychiatric Care	☐ X-ray or Cobalt Treatment
☐ Diabetes	☐ Hepatitis C	☐ Recent Weight Loss	☐ Yellow Jaundice

Have you ever had any other serious illness not circle above? **YES** **NO**
Please describe in detail; _____
Are you being/have you ever been treated for cancer of any kind? **YES** **NO**
Please explain; _____
Do you wish to talk to the doctor privately about any problems/concerns? **YES** **NO**

_____ _____
Signature of Patient or Responsible Party Date

Reviewed by: _____ _____ _____
(Title) Date BP

MEDICAL UPDATES
I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patient's Signature	BP	Pulse	Reviewed by
_____	_____	NONE ☐	_____	_____	_____	Dr/RDH _____
_____	_____	NONE ☐	_____	_____	_____	Dr/RDH _____
_____	_____	NONE ☐	_____	_____	_____	Dr/RDH _____
_____	_____	NONE ☐	_____	_____	_____	Dr/RDH _____
_____	_____	NONE ☐	_____	_____	_____	Dr/RDH _____
_____	_____	NONE ☐	_____	_____	_____	Dr/RDH _____