

PATIENT MEDICAL HISTORY

Patient Name _____ **Date** _____

Physician _____ **Office PH.** _____ **Date of Last Exam** _____

1. Are you under a physicians care now? _____ Explain _____
2. Have you ever been hospitalized or had a surgical procedure? _____ In the last 5 yrs? _____ Explain _____
3. Have you ever had a serious head or neck injury? _____ Explain _____
4. Have you ever taken, Phen-Fen, Redux, Boniva, Fosamax, Actonel or any cancer medications containing bisphosphonates?
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?
6. Are you on a special diet? _____ Explain _____
7. Do you smoke? _____ use tobacco? _____ How often? _____
8. Do you use controlled substances? _____ Frequency? _____
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasted more than 3 wks)? _____
10. Are you allergic to any of the following: Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other _____, Explain _____
11. Are you taking medications (including non prescription medicines): _____ If yes, Please List: _____

Ask for a separate sheet of paper if you need it.

Women: Are you : Pregnant/Trying to get pregnant? _____ Taking Oral Contraceptives? _____ Nursing? _____

Do you have or have you had any of the following?

- | | | | |
|--|--|---|--|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Heart Trouble | <input type="radio"/> Chest Pains | <input type="radio"/> AIDS or HIV Positive/Infection |
| <input type="radio"/> Heart Attack/Failure/Disease | <input type="radio"/> Cardiac Pacemaker | <input type="radio"/> Easily Winded | <input type="radio"/> Sexually Transmitted Disease |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Heart Murmur | <input type="radio"/> Stroke | <input type="radio"/> Cold Sores/Fever Blisters |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Artificial Joint | <input type="radio"/> Blood Disease | <input type="radio"/> Alzheimer's Disease |
| <input type="radio"/> Low Blood Pressure | <input type="radio"/> Bruise Easily | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Anaphylaxis |
| <input type="radio"/> Cortisone Medicine | <input type="radio"/> Herpes | <input type="radio"/> Excessive Bleeding/Hemophilia | <input type="radio"/> Thyroid Problem |
| <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Psychiatric Care | <input type="radio"/> Radiation Therapy | <input type="radio"/> Stomach Troubles/Ulcers |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Renal Dialysis | <input type="radio"/> Sickle Cell Disease | <input type="radio"/> Hepatitis B or C |
| <input type="radio"/> Spina Bifida | <input type="radio"/> Tumors or Growths | <input type="radio"/> Yellow Jaundice | <input type="radio"/> Hepatitis A |
| <input type="radio"/> Shingles | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Lung Disease | <input type="radio"/> Kidney Diseases |
| <input type="radio"/> Swollen Ankles | <input type="radio"/> Angina | <input type="radio"/> Hay Fever/Allergies | <input type="radio"/> Joint Replacement or Implant |
| <input type="radio"/> Fainting/Dizziness | <input type="radio"/> Frequently Tired | <input type="radio"/> Tuberculosis | <input type="radio"/> Diabetes |
| <input type="radio"/> Asthma | <input type="radio"/> Anemia | <input type="radio"/> Radiation Therapy | <input type="radio"/> Liver Disease |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Emphysema | <input type="radio"/> Glaucoma | <input type="radio"/> Epilepsy/Seizures/Convulsions |
| <input type="radio"/> Recent Weight Loss | <input type="radio"/> Cancer | <input type="radio"/> Leukemia | <input type="radio"/> Arthritis |

Have you had any serious illness not listed above? _____

Comments: _____

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 (patient's) health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

Signature of patient (or parent/guardian if minor)

Date

Doctors Comments:

Doctor Signature

Date