MEDICAL HISTORY
Please fill in completely

1. Patient Name: _____ D.O.B.: _____ Sex: ___M ___F
2. Address: _____City:_____ State: ____ Zip: _____
3. Home Phone: (___)-_____-_____Work Phone (___)-_____-_____Cell Phone (___)-_____-_____

4. Former Dentist Name (new patients only):_____ Last Dental Visit: _____
5. Name and Address of Physician _____
6. Date of Last Medical Examination: _____
7. Are you under the care of a physician?: ____Yes _____No
8. List all medications or drugs and dosages you are presently taking:

_____
_____

9. Do you use tobacco or smoke? ____Yes _____No
10. What surgeries have you had and/or have you been advised of the need for any type of surgery?

_____
_____

11. (Women) Are you pregnant? _____Yes _____No If so, how far along? _____
12. Are you allergic to: ____Penicillin ____Latex ____Local Anesthetic
    Other: _____

13. Do you have, or have you ever had?

Heart disease	___Yes ___No		
Circulatory problems	___Yes ___No	Anemia	___Yes ___No
Heart murmur	___Yes ___No	Arthritis	___Yes ___No
Rheumatic fever	___Yes ___No	Asthma or hay fever	___Yes ___No
Congenital heart defects	___Yes ___No	Back problems	___Yes ___No
Abnormal blood pressure	___Yes ___No	Chemical dependency	___Yes ___No
Diabetes	___Yes ___No	Fainting spells	___Yes ___No
Excessive urination or thirst	___Yes ___No	Glaucoma	___Yes ___No
Epilepsy	___Yes ___No	Headaches (frequent)	___Yes ___No
Exposure to the AIDS virus	___Yes ___No	Jaundice	___Yes ___No
Excessive or prolonged bleeding	___Yes ___No	Excessively nervous or anxiety	___Yes ___No
Stroke	___Yes ___No	Chemo/Radiation Therapy	___Yes ___No
Prosthetic implant	___Yes ___No	When?	_____
Tuberculosis or lung disease	___Yes ___No	Sinus Trouble	___Yes ___No
Hepatitis – Type _____	___Yes ___No	Thyroid Trouble	___Yes ___No
Step Throat – When? _____	___Yes ___No	Tonsillitis	___Yes ___No
Sexually transmitted disease	___Yes ___No	Tumors	___Yes ___No
High cholesterol	___Yes ___No		

14. Have you been advised to be pre-medicated prior to dental treatment for any of the above conditions?
____Yes ____No Reason: _____

15. Have you had any other serious illness, hospitalization or accident? ____Yes ____No

16. Is there anything else we should know about your medical history?

_____
_____
_____

Patient Signature: _____ Date: _____
(Parent or Guardian, if minor)
Recorded By: _____D.D.S. Signature: _____

Medical Explanations from Question #13:
____
____
____

UPDATED: ____/_____/_________ Changes:___________________________________ ___________________________________ ___________________________________ Patient Signature: __________________________	UPATED: ____/_____/_________ Changes:___________________________________ ___________________________________ ___________________________________ Patient Signature: __________________________
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