Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes ☐ No ☐
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes ☐ No ☐
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes ☐ No ☐
   If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? ..... Yes ☐ No ☐
   If yes, did you take any of the following? (circle if yes) Fen-Phen ☐ Pondimen ☐ Redux ☐ Other ☐
   If yes to any of the above, did you have a medical exam for heart issues? ..... Yes ☐ No ☐
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes ☐ No ☐
6. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes ☐ No ☐
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ..... Yes ☐ No ☐
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐	Hepatitis A○B○C○(circle) ...	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Congenital Heart Disease	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐	A.I.D.S./H.I.V. Positive	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Cold Sores/Fever Blisters	Yes ☐ No ☐
High/Low Blood Pressure	Yes ☐ No ☐	Contact lenses	Yes ☐ No ☐	Blood Transfusion	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐
Artificial Heart Valve/Pacemaker	Yes ☐ No ☐	Chronic Cough	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐	Bruise Easily	Yes ☐ No ☐
Arthritis/Rheumatism	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Liver Disease/Yellow Jaundice ..	Yes ☐ No ☐
Cortisone Medicine	Yes ☐ No ☐	Hay Fever/Allergy/Hives	Yes ☐ No ☐	Neurological Disorders	Yes ☐ No ☐
Swollen Ankles	Yes ☐ No ☐	Latex Sensitivity	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐	Fainting or Dizzy Spells	Yes ☐ No ☐
Diet (Special/Restricted)	Yes ☐ No ☐	Radiation Therapy	Yes ☐ No ☐	Nervous/Anxious	Yes ☐ No ☐
Artificial Joints (hip, knee, etc.)	Yes ☐ No ☐	Chemotherapy	Yes ☐ No ☐	Psychiatric/Psychological Care..	Yes ☐ No ☐
Kidney Trouble	Yes ☐ No ☐	Tumors	Yes ☐ No ☐		

9. Have you lost or gained more than 10 pounds in the past year? ..... Yes ☐ No ☐
10. Do you have or have you had any disease, condition, or problem not listed? ..... Yes ☐ No ☐
    If yes, please list: _____
11. **Women:** Are you pregnant or think you could be pregnant? ☐ Yes _____ Months ☐ No **Nursing?** ☐ Yes ☐ No
12. Do you use birth control prescriptions? ..... Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____