Medical History

Have you been under the care of a medical doctor during the past two years? **Y/N**
If yes, for what? ____________________
Physicians Name ____________________
Address ____________________ Phone ____________________
Have you taken any medication or drugs in the past two years? **Y/N**
Are you taking any medication, drugs, or pills now, including aspirin? **Y/N**
If yes, please list names and dosage ____________________
Are you aware of having any allergic (or adverse) reaction to any medication or substance? **Y/N**
If yes, please list and briefly explain ____________________
Have you been hospitalized in the last five years? **Y/N**
If yes, please briefly explain ____________________

WOMEN: Are you: Pregnant **Y/N** Nursing **Y/N** Taking birth control **Y/N**

Please circle Y or N if you have had or have at present, the following:

Heart (Surgery, disease, attack)	**Y/N**	Hay Fever	**Y/N**
Chest Pain	**Y/N**	Latex Sensitivity	**Y/N**
Congenital heart disease	**Y/N**	Allergies or Hives	**Y/N**
Heart Murmur	**Y/N**	Sinus Trouble	**Y/N**
High Blood Pressure	**Y/N**	Radiation Therapy	**Y/N**
Artificial Heart Valve	**Y/N**	Chemotherapy	**Y/N**
Mitral Valve Prolapse	**Y/N**	Tumors	**Y/N**
Heart Pacemaker	**Y/N**	Hepatitis A B C (circle)	**Y/N**
Rheumatic Fever	**Y/N**	Venereal Disease	**Y/N**
Arthritis/Rheumatism	**Y/N**	AIDS	**Y/N**
Cortisone Medication	**Y/N**	HIV	**Y/N**
Swollen Ankles	**Y/N**	Cold sore/ Fever Blister	**Y/N**
Stroke	**Y/N**	Blood Transfusion	**Y/N**
Diet (Special, restricted)	**Y/N**	Hemophilia	**Y/N**
Artificial Joints	**Y/N**	Sickle Cell Disease	**Y/N**
Kidney Trouble	**Y/N**	Bruise Easily	**Y/N**
Ulcers	**Y/N**	Liver Disease	**Y/N**
Thyroid Problems	**Y/N**	Yellow Jaundice	**Y/N**
Glaucoma	**Y/N**	Neurological Disorder	**Y/N**
Emphysema	**Y/N**	Epilepsy/Seizures	**Y/N**
Chronic Cough	**Y/N**	Fainting/Dizzy spells	**Y/N**
Tuberculosis	**Y/N**	Nervous/Anxious	**Y/N**
Asthma	**Y/N**	Psychiatric Care	**Y/N**
Diabetes	**Y/N**	High Cholesterol	**Y/N**

Do you have any disease, problem or condition not listed above? **Y/N**
If yes, please list:

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I am aware that this information is needed to provide me with dental care in a safe manner. All of the questions have been answered to the best of my knowledge. If any changes are to occur, I will notify the doctor with any changes in my health or medications.

Patient/Guardian Signature ____________________ **Date** ____________________