| Patient Name | |
|---|---|
| Patient Account No. | Medical Alert |

# MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? ..... YES ◯ NO ◯

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? ..... YES ◯ NO ◯

3. Are you taking any medication, drugs or pills now? ..... YES ◯ NO ◯

If yes, please list name and dosage _____

4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... YES ◯ NO ◯

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? ..... YES ◯ NO ◯

6. 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 (infectious) B (serum) | 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. | YES ◯ NO ◯ |
| Heart Murmur | YES ◯ NO ◯ | Glaucoma | YES ◯ NO ◯ | H.I.V. Positive | YES ◯ NO ◯ |
| High Blood Pressure | YES ◯ NO ◯ | Contact Lenses | YES ◯ NO ◯ | Cold Sores /Fever Blisters | YES ◯ NO ◯ |
| Mitral Valve Prolapse | YES ◯ NO ◯ | Emphysema | YES ◯ NO ◯ | Blood Transfusion | YES ◯ NO ◯ |
| Artificial Heart Valve | YES ◯ NO ◯ | Chronic Cough | YES ◯ NO ◯ | Hemophilia | YES ◯ NO ◯ |
| Heart Pacemaker | YES ◯ NO ◯ | Tuberculosis | YES ◯ NO ◯ | Sickle Cell Disease | YES ◯ NO ◯ |
| Rheumatic Fever | YES ◯ NO ◯ | Asthma | YES ◯ NO ◯ | Bruise Easily | YES ◯ NO ◯ |
| Arthritis/Rheumatism | YES ◯ NO ◯ | Hay Fever | YES ◯ NO ◯ | Liver Disease | YES ◯ NO ◯ |
| Cortisone Medicine | YES ◯ NO ◯ | Latex Sensitivity | YES ◯ NO ◯ | Yellow Jaundice | YES ◯ NO ◯ |
| Swollen Ankles | YES ◯ NO ◯ | Allergies or Hives | YES ◯ NO ◯ | Neurological Disorders | YES ◯ NO ◯ |
| Stroke | YES ◯ NO ◯ | Sinus Trouble | YES ◯ NO ◯ | Epilepsy or Seizures | YES ◯ NO ◯ |
| Diet (Special/Restricted) | YES ◯ NO ◯ | Radiation Therapy | YES ◯ NO ◯ | Fainting or Dizzy Spells | YES ◯ NO ◯ |
| Artificial Joints (hips, knee, etc.) | YES ◯ NO ◯ | Chemotherapy | YES ◯ NO ◯ | Nervous/Anxious | YES ◯ NO ◯ |
| Kidney Trouble | YES ◯ NO ◯ | Tumors | YES ◯ NO ◯ | Psychiatric/Psychological Care | YES ◯ NO ◯ |

7. Do you use more than two pillows to sleep? ..... YES ◯ NO ◯

8. Have you gained or lost more than 10 pounds in the past year? ..... YES ◯ NO ◯

9. Do you have or had any disease, condition, or problem not listed? ..... YES ◯ NO ◯

If yes, please list: ..... YES ◯ NO ◯

10. **Women.** Are you: **Pregnant?** YES ◯ ___months NO ◯ **Nursing** YES ◯ NO ◯ **Taking birth control pills?** YES ◯ NO ◯

***I understand the above information is necessary to provide me with the 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**

Doctor's Signature Date