MEDICAL HISTORY

Patient Name: _____

Physician's Name: _____ Phone Number _____

1. Have you had any major medical care within the past two years? Yes No
   Describe: _____
2. Have you taken any prescription medication during the past two years? *(use back if more room is needed)* Yes No
   Name of drug(s), dosage and reason for taking: _____
3. Have you ever taken prescription drugs for weight loss (diet pills) Yes No
   If yes, did you take any of the following (circle all that apply): Fen-Phen Pondimen Redux Other
   If yes to any of the drugs listed, did you have a medical exam for heart issues? Yes No
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, other? Yes No
5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
   If yes, please specify: _____
6. Have you been a patient in the hospital during the past five years? Yes No
7. Have you had or have sleep apnea? Yes No

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	AIDS/HIV 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	Headaches (migraines, tension)	Yes	No

7. Have you been told that you should take a pre-medication before dental appointments? Yes No
   If yes, why: _____ Which medication do you take ?_____
8. Do you have, or have you had, any disease, condition or problem not listed above? Yes No
   If yes, please list: _____
9. **Women** – Are you pregnant or think you could be pregnant? Yes No _____ months Are you nursing? Yes No
   Do you use prescription birth control? 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 changes in my health or medication.

Patient/Guardian Signature: _____ Date: _____

For Office Use - History Review / Medical Alerts

Dentist Signature: _____ Date: _____