

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

- 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 _____
 - Have you taken any medication or drugs during the past two years?..... Yes No
 - Are you taking any medication, drugs, or pills now?..... Yes No
If yes, please list name(s) and dosage(s) _____
 - Have you ever taken prescription medications for weight loss (diet pills)?..... Yes No
If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phentermine)
Yes No Pondimin (Fenfluramine)
Yes No Redux (Dexfenfluramine)
If yes to any of the above, did you have a medical exam for heart issues?..... Yes No
 - Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No
If yes, please list: _____
 - Have you been a patient in the hospital during the past five years?..... 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 (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 (hip, knee, etc.)..... | Yes | No | Chemotherapy..... | Yes | No | Nervous/Anxious..... | Yes | No |
| Kidney Trouble..... | Yes | No | Tumors..... | Yes | No | Psychiatric/Psychological Care..... | Yes | No |
- Do you use more than two pillows to sleep?..... Yes No
 - Have you lost or gained more than 10 pounds in the past year?..... Yes No
 - Do you have or have you had any disease, condition, or problem not listed?..... Yes No
If yes, please list: _____
 - 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 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 healthcare provider or agency, who may release such information to you. I will notify the doctor of changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____