

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_

### Please answer each question. Circle Yes or No where applicable:

1. Are you in good health?..... Yes No
2. Date of last physical exam \_\_\_\_\_
3. Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_
4. Have you had any serious operations or been hospitalized?..... Yes No  
If yes, Please Explain? \_\_\_\_\_
5. Are you taking any medication? ..... Yes No  
If yes, please list: \_\_\_\_\_
6. Are you using any recreational drugs (marijuana, cocaine, etc.)?..... Yes No  
If yes, what? \_\_\_\_\_
7. Are you **sensitive** or **allergic** to any drugs or medications? ..... Yes No  
Amoxicillin Aspirin Codeine Dental Anesthetics Erythromycin Keflex  
Latex Penicillin Sulfa Drugs Tetracycline Other, please list them:  
\_\_\_\_\_

### Please check any of the following you may have or have had in the past:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Angina Pectoris       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Prosthesis | <input type="checkbox"/> Fainting Spells     | <input type="checkbox"/> Mitral Valve         | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | _____                                     |
| <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Pace Maker           | _____                                     |
| <input type="checkbox"/> Blood Transfusion     | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Psychiatric Problems |   |
| <input type="checkbox"/> Bruise Easily         | <input type="checkbox"/> Heart Failure       | <input type="checkbox"/> Radiation Therapy    |   |
| <input type="checkbox"/> Cancer/Chemo          | <input type="checkbox"/> Heart Lesions       | <input type="checkbox"/> Respiratory Disease  |   |
| <input type="checkbox"/> Cerebral Palsy        | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      |   |
| <input type="checkbox"/> Cold Sores            | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Scarlet Fever        |   |
| <input type="checkbox"/> Cortisone Medication  | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Sickle Cell Disease  |   |
| <input type="checkbox"/> C-Pap Machine         | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Sinus Problems       |   |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke               |   |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> HIV/Aids            | <input type="checkbox"/> Taken Fen-Phen       |   |
| <input type="checkbox"/> Drug Abuse            | <input type="checkbox"/> Joint Replacement   | <input type="checkbox"/> Thyroid Problems     |   |

8. **Do you need antibiotic pre-medication for your dental treatment?** ..... Yes No
9. Do you have or have you have any disease, condition, or problem not listed? Yes No  
If Yes, Please List: \_\_\_\_\_
10. Do you smoke? ..... Yes No  
If Yes, how many per day? \_\_\_\_\_
11. **WOMEN:** Are you pregnant or think you could be Pregnant? ..... Yes No  
If Yes, How many months? \_\_\_\_\_ Nursing? Yes No
12. **WOMEN:** Do you use birth control prescriptions? ..... Yes No

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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: \_\_\_\_\_

## Health History Updates

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any changes in my health, or medications, I will, without fail, inform the doctors at my next appointment.

**Year 1:** Date: \_\_\_\_\_  
Health Changes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name \_\_\_\_\_  
Physician's Phone \_\_\_\_\_  
Patient Signature \_\_\_\_\_

Current Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Initials \_\_\_\_\_

**Year 2:** Date: \_\_\_\_\_  
Health Changes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name \_\_\_\_\_  
Physician's Phone \_\_\_\_\_  
Patient Signature \_\_\_\_\_

Current Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Initials \_\_\_\_\_

**Year 3:** Date: \_\_\_\_\_  
Health Changes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name \_\_\_\_\_  
Physician's Phone \_\_\_\_\_  
Patient Signature \_\_\_\_\_

Current Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Initials \_\_\_\_\_