MEDICAL HISTORY

Patient Name	
Patient Chart Number	Medical Alert

1. Do you have a primary care doctor you see annually?_____ Yes No

   If yes, physician name_____

2. Do you have a specialty doctor? **Yes** **No** If yes, specialist name_____ Type_____
3. Have you been hospitalized in the past 5 years? **Yes** **No** If yes, for what? _____
4. Are you taking any medication, drugs, or pills? _____ Yes No

   If yes, please list:_____
   (you may use the back of this form if necessary)

5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? _____ Yes No

   If yes, please list:_____

6. Are you taking oral steroids (Prednisone, Cortisone, Hydrocortisone) or bisphosphonates (Fosamax, Reclast, Boniva)?_____ Yes No
7. Indicate which of the following you have had or have at the present time. **Circle "Yes" to what applies to you**.

High Blood Pressure	Yes	No	Asthma	Yes	No	Venereal Disease (STD)	Yes	No
Chest Pain	Yes	No	Emphysema	Yes	No	A.I.D.S.	Yes	No
Heart Disease	Yes	No	Tuberculosis	Yes	No	H.I.V. Positive	Yes	No
Heart Attack	Yes	No	Chronic Cough	Yes	No	Tumors	Yes	No
Heart Stent	Yes	No	Liver Disease	Yes	No	Radiation Therapy	Yes	No
Heart Pacemaker	Yes	No	Hepatitis A, B, or C	Yes	No	Chemotherapy	Yes	No
Heart Murmur	Yes	No	Hemophilia	Yes	No	Neurological Disorder	Yes	No
Mitral Valve Prolapse	Yes	No	Sickle Cell Disease	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Bruise Easily	Yes	No	Fainting/Dizzy Spells	Yes	No
Arthritis/Rheumatism	Yes	No	Blood Transfusion	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints	Yes	No	Kidney Trouble	Yes	No	Psychological Care	Yes	No
Thyroid Problems	Yes	No	Ulcers/GERD	Yes	No	Seasonal Allergies	Yes	No
Diabetes	Yes	No	Contact Lenses	Yes	No	Sinus Trouble	Yes	No
						Latex Sensitivity	Yes	No

8. Have you lost or gained more than 10 lbs. in the past year? _____ Yes No
9. Do you have or have you had any disease, condition, or problem not listed? _____ Yes No

   If yes, please list:_____

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 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 changes in my health or medication.

Patient Signature_____ **Date:**_____

History Review

Dentist Signature _____ Date _____

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