## MEDICAL HISTORY INFORMATION

**Name of Patient:**_____

**Name of Physician:**_____ **Phone#:**_____

**Do you have or have you ever had any of the following? Please check those that apply:**

| | | | |
|---|---|---|---|
| ( ) Allergies/ Hay fever | ( ) Diabetes | ( ) Heart Surgery* | ( ) Rheumatism |
| ( ) Anemia | ( ) Epilepsy/ Seizures | ( ) Hepatitis | ( ) Rheumatic Fever |
| ( ) Angina | ( ) Excessive Thirst | ( ) High Blood Pressure | ( ) Sickle Cell Disease |
| ( ) Arthritis | ( ) Fainting or Dizziness | ( ) HIV*/ AIDS | ( ) Sinus Problems |
| ( ) Artificial Joints* | ( ) Fever Blisters/ Cold Sores | ( ) Kidney Problems | ( ) Stroke |
| ( ) Artificial Heart Valves* | ( ) Frequent Coughs | ( ) Liver Problems | ( ) Surgical Shunt* |
| ( ) Asthma | ( ) Glaucoma | ( ) Mental Disorders | ( ) Thyroid problems |
| ( ) Breathing Problems | ( ) Heart Disorder (congenital)* | ( ) Mitral Valve Prolapse* | ( ) Tuberculosis |
| ( ) Cancer | ( ) Heart Infection * | ( ) Osteoporosis | ( ) Ulcers |
| ( ) Chemical Dependency | ( ) Heart Murmur* | ( ) Radiation treatment | ( ) Venereal Disease |
| ( ) Chemotherapy | ( ) Heart Pace Maker* | ( ) Respiratory Problems | ( ) Yellow Jaundice |

***This condition may require antibiotic premedication for certain dental procedures**

**YES NO**

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?

If yes, explain: _____

[ ] [ ] Are you now under the care of a physician?

If yes, explain: _____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, explain: _____

[ ] [ ] Are you taking any medications or herbals?

If yes, explain: _____

[ ] [ ] Are you allergic to any medications or substances?

If yes, please check box below: [ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] metal [ ] latex [ ] Other____

[ ] [ ] have you used tobacco?

If yes, explain:_____

**Women (please check):** [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

**Signature X**_____ **Date**_____

**MEDICAL UPDATES**

**I have read my MEDICAL HISTORY dated_____ and confirm that it states past and present conditions**

| DATE: | Exceptions: | [ ] None | Patient's Signature: |
|---|---|---|---|
| _____ | _____ | | X_____ |
| _____ | _____ | | X_____ |