Medical History

Patient Name

1. 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 _____
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin?..... Yes No
   If yes, please list name _____
4. Are you, or have you ever taken a bone density medication or derivative?..... Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No
   If yes, please list: _____
6. 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 or B…….	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

7. Do you use more than two pillows to sleep?.....……..…….. Yes No
8. Have you lost or gained more than 10 pounds 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 change in my health or medication.

Patient/Guardian Signature _____ Date _____