Medical History

Physician's name: _____ Date of last visit: _____

Have you had any of the following:

- o Anemia
- o Alzheimer's disease
- o AIDS, HIV
- o Artificial heart valves
- o Artificial joints
- o Asthma
- o Angina
- o Back problems
- o Bleeding abnormally after extractions or surgery
- o Blood disease
- o Cancer
- o Chemical dependency
- o Chemotherapy
- o Chest pain upon exertion
- o Circulatory problems
- o Congenital heart defects
- o Cortisone treatments
- o Persistent or bloody cough
- o Diabetes
- o Epilepsy, convulsions
- o Fainting or dizziness
- o Headaches, migraines
- o Heart murmur
- o Heart valve problems
- o Heart attack
- o Hepatitis, type: _____
- o Herpes
- o High blood pressure
- o Hypoglycemia
- o Jaundice
- o Joint replacement
- o Kidney disease
- o Liver disease
- o Low blood pressure
- o Mitral valves prolapse
- o Neurological problems
- o Pacemaker
- o Psychiatric care
- o Radiation treatment
- o Respiratory disease
- o Rheumatic fever
- o Sleep disorder
- o Shortness of breath
- o Sinus trouble
- o Stroke
- o Substance abuse
- o Swollen neck glands
- o Thyroid problems
- o Tuberculosis
- o Tumor or growth on head or neck
- o Reflux, heartburn
- o Venereal disease
- o Hospitalized in last 2 years
- o Illness or impending medical treatment that may affect your dental treatment_____
  _____
  _____
  _____

Women:

- o Pregnant, due date
  _____
- o Nursing
- o Taking birth control pills

Please list the medications you are currently taking: _____

_____

Pharmacy name: _____ Phone: _____

Allergies:

- o Aspirin
- o Motrin
- o Codeine
- o Latex
- o Local anesthetic
- o Penicillin
- o Sulfa
- o Metal
- o Other: _____
  _____
  _____
  _____

My medical history is accurate and complete. I understand it is my responsibility to inform the dental office of any changes in my medical status. I give permission for my dentist and clinical team to take any necessary x-rays, photos, and study models to make s complete diagnosis of my dental needs. I consent to use my dental information to obtain insurance payment.

_____

Parent or Guardian's Signature Today's date

In case of emergency please contact:

Name: _____ Relationship to you: _____

Address: _____ Phone: _____