Dental Professionals

Medical History

Patient Name | **Date**

1. Physician's Name_____Phone ( ) _____
   Have you had any medical care within the past two years? . . . . . Yes | No
   Describe_____
2. Are you in pain now? . . . . . Yes | No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? . . . Yes | No
   If yes, what?_____
4. Are you allergic to any of the below? . . . . . .
   Aspirin | Ibuprofen | Sulfa Drugs | Penicillin | Latex | Codeine | Local Anesthetics | Other_____
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? . . . . . Yes | No
6. Have you been hospitalized during the past five years? . . . . . Yes | No
   If yes, why?_____
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	Kidney Trouble	Yes | No	Venereal Disease	Yes | No
Chest Pain (Angina)	Yes | No	Ulcers	Yes | No	AIDS/ HIV Positive	Yes | No
Congenital Heart Disease	Yes | No	Thyroid Problems	Yes | No	Cold Sores	Yes | No
Heart Murmur	Yes | No	Glaucoma	Yes | No	Blood Transfusion	Yes | No
High / Low Blood Pressure	Yes | No	Shortness of Breath	Yes | No	Clotting Disorder	Yes | No
Mitral Valve Prolapse	Yes | No	Emphysema	Yes | No	Sickle Cell Disease	Yes | No
Artificial Heart Valve	Yes | No	Chronic Cough	Yes | No	Bruise Easily	Yes | No
Pacemaker	Yes | No	Tuberculosis	Yes | No	Liver Disease	Yes | No
Rheumatic Fever	Yes | No	Asthma	Yes | No	Seizures	Yes | No
Arthritis / Rheumatism	Yes | No	Hay Fever	Yes | No	Fainting	Yes | No
Diabetes- Type_____	Yes | No	Sinus Trouble	Yes | No	Nervous / Anxiety	Yes | No
Swollen Ankles	Yes | No	Radiation Therapy	Yes | No	Psychiatric Care	Yes | No
Anemia	Yes | No	Chemotherapy	Yes | No		
Stroke	Yes | No	Tumors	Yes | No		
Artificial Joints	Yes | No	Hepatitis	Yes | No		
Hip | Knee | Shoulder | Other		A | B | C			

7. Do you have or have you had any other disease, condition or problem not listed above? Yes | No
   If Yes, what? _____
8. WOMEN: Are you pregnant, or think you could be pregnant? Yes | No Are you nursing? Yes | No
   Are you currently taking birth control? Yes | No

I understand the above information in 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_____

Review:

Patient Signature_____ Date _____

Patient Signature_____ Date _____