MEDICAL HISTORY

Patient's Name: _____

Physician's Name: _____ Current Treatment? _____
Have you ever been hospitalized or had a major operation? Explain _____
Have you ever had a serious injury? Explain _____

Please list any **medications** you are taking: (if additional, attach list and check box ☐) ☐ **No Current Medications**

_____ _____ _____ _____
_____ _____ _____ _____

Are you **allergic to** any medications or substances? (Check box or explain below)

☐ Aspirin ☐ Penicillin ☐ Erythromycin ☐ Other Antibiotics _____ ☐ Codeine

☐ Metal _____ ☐ Latex ☐ Local Anesthetics _____

☐ Other Allergies _____ ☐ **No Allergies**

WOMEN: Are you **pregnant**? ☐ Yes ☐ No ☐ Trying to get pregnant ☐ Nursing ☐ Taking contraceptives _____

PLEASE CHECK ***YES*** OR ***NO*** TO ALL THE FOLLOWING: (Note: those with an ∗ may require premedication prior to your appointment)

	yes	no		yes	no		yes	no		yes	no		yes	no
Heart trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur *	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Hearbeat	☐	☐	Bleed alot	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/chest pain	☐	☐	Sickle cell dis.	☐	☐	Radiation treatments	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart attack/failure	☐	☐	Bleeding Prob.	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Dis.	☐	☐	Leukemia	☐	☐	Stomach/Intest.Dis.	☐	☐	Arthritis/Gout	☐	☐	Epilepsy/Seizures	☐	☐
Mitral Valve Prolapse*	☐	☐	Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting/Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling limbs	☐	☐	Recent Weight loss	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors/Growths	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Prob.	☐	☐	Diabetes	☐	☐	Artificial Joint*	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Short Breath	☐	☐	Excessive thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery*	☐	☐	Freq. Cough	☐	☐	Hypglycemia	☐	☐	AIDS	☐	☐	Alzheimer's	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergic to Drugs	☐	☐
Low Blood Pressure	☐	☐	Sinus Problem	☐	☐	Hepatitis A	☐	☐	Genital Herpes	☐	☐	Allergic to Pollens	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B	☐	☐	Substance Abuse	☐	☐	Hives or Rash	☐	☐

Please list any other illness not checked above _____

To the best of my knowledge, all of the preceding information is accurate and correct. I will notify the dentist or staff of any changes in my medical history. SIGNED _____ Date _____
patient signature (or parent/guardian)

MEDICAL HISTORY UPDATES (complete yearly)

Date	Change		BP/Pulse	staff
_____	_____	☐ None	_____	____
_____	_____	☐ None	_____	____
_____	_____	☐ None	_____	____
_____	_____	☐ None	_____	____
_____	_____	☐ None	_____	____
_____	_____	☐ None	_____	____
_____	_____	☐ None	_____	____