Patient Name _____ Date _____

Medical History

Your Physician's Name _____ Phone _____

Pharmacy you prefer _____ Phone _____

Are you under physician's care now? Why? _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, pills or drugs? What? _____ Yes No

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below _____ Yes No

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other _____

Women (Please check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes.

*If yes to any of the starred conditions, understand premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Murmur*	❑	❑	Heart Surgery	❑	❑	Liver Disease	❑	❑	Convulsions	❑	❑
Mitral Valve Prolapse*	❑	❑	High Blood Pressure	❑	❑	Hepatitis A	❑	❑	Epilepsy or Seizures	❑	❑
Artificial Heart Valve*	❑	❑	Stroke	❑	❑	Hepatitis B or C	❑	❑	Fainting	❑	❑
Rheumatic Fever*	❑	❑	Hemophilia/Excessive Bleeding	❑	❑	Stomach/Intestinal Disease	❑	❑	Cold Sores/Fever Blisters	❑	❑
Prosthetic Heart Pace Maker*	❑	❑	Asthma	❑	❑	Tuberculosis	❑	❑	Apthous Ulcer/Canker Sores	❑	❑
Artificial Joint*	❑	❑	Emphysema	❑	❑	Kidney Problems	❑	❑	Venereal Disease	❑	❑
Splenectomy*	❑	❑	Cancer	❑	❑	Renal Dialysis	❑	❑	AIDS	❑	❑
Immunocompromised*	❑	❑	Tumors or Growths	❑	❑	Thyroid Disease	❑	❑	HIV Positive	❑	❑
Congenital Heart Disorder	❑	❑	Chemotherapy	❑	❑	Parathyroid Disease	❑	❑	Alzheimer's Disease	❑	❑
Angina/Chest Pain	❑	❑	Radiation Treatment	❑	❑	Arthritis/Gout	❑	❑	Psychiatric Care	❑	❑
Heart Attack	❑	❑	Diabetes	❑	❑	Cortisone Treatment	❑	❑	Drug Addiction	❑	❑

Have you ever had any other serious illness not checked above? Discuss _____

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

X_____ Date _____

PATIENT SIGNATURE (Parent or Guardian)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings_____

_____

Medical Updates

I have read my medical history dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____