Medical History

Patient Name

Medical Alert

1.Physician Name _____ **Phone( )** _____

Have you had any medical care within the past two years? ..... Yes No

Describe _____

2.Have you taken any medication or drugs during the past two years? ..... Yes No

If yes, please list name and dosage _____

3.Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of apirin? .....Yes No

If yes, please list name and dosage _____

4.Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other bisphosphonates? ..... Yes No

If yes, please list name and dosage _____

Woman: Are You... ☐ **Pregnant/Trying to get pregnant?** ☐ **Nursing** ☐ **Taking oral Contraceptives?**

Are you allergic to any of the following?

☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Metal** ☐ **Latex** ☐ **Sulfa Drugs** ☐ **Local Anesthetics**

Other? If Yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Breathing Problems	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No			

Have you ever had any serious illness not listed above? If Yes _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the 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** _____

Office Notes