CONFIDENTIAL

MEDICAL HISTORY

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

Check (✓) if you have or have had problems with any of the following:

AIDS/HIV Positive	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Neurological Problems	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Endocarditis	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma or Hay Fever	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
		Hemophilia	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer Therapy	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Claustrophobia	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Contact Lenses	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Measles or mumps	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nasal Obstruction	☐ Yes ☐ No		

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (✓) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

	Presently Taking	Taken in the Past	History of Reaction
Anesthetics, Locally Injected	☐	☐	☐
Anesthetics, General	☐	☐	☐
Antacids	☐	☐	☐
Anti-anxiety Medications	☐	☐	☐
Anti-depressants	☐	☐	☐
Antihistamines	☐	☐	☐
Daily Aspirin Regimen	☐	☐	☐
Birth Control Pills	☐	☐	☐
Blood Pressure Medications	☐	☐	☐
Codeine, Demerol or Other Analgesics	☐	☐	☐
Cortisone or Other Steroids	☐	☐	☐
Coumadin, Heparin, Warfarin or other blood thinners	☐	☐	☐
Dilantin	☐	☐	☐
Diuretics (water pills)	☐	☐	☐
Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine)	☐	☐	☐
Heart Medications such as Digoxin, Nitroglycerin or Digitalis	☐	☐	☐
Ibuprofen (Motrin)	☐	☐	☐
Insulin or Diabetes Medications	☐	☐	☐
Sedatives or Tranquilizers	☐	☐	☐
Sleeping Pills (Barbiturates)	☐	☐	☐
Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine	☐	☐	☐
Tylenol (Acetomeniphen)	☐	☐	☐
Adverse reaction to any other medication or drug	☐ Yes ☐ No		

Please specify _____

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

Medication	Condition	Prescribing Doctor

Pharmacy Name _____ Phone ( ) _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Have you had any serious illnesses or surgeries? ☐ Yes ☐ No If yes, describe _____

Check (✓) your current use of:

Tobacco ☐ Yes ☐ No
Packs per day _____
Alcohol, Beer, Wine ☐ Yes ☐ No
Drinks per day _____
Street Drugs ☐ Yes ☐ No
Times per day _____
Caffeine ☐ Yes ☐ No
Cups per day _____
High Stress ☐ Yes ☐ No
Reason _____

Do you have any other health needs you should bring to our attention? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient