

PATIENT'S NAME

DATE:

Medical History Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV/ARC | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy
Due date: _____ | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tetracycline Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Aspirin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur/MVP | <input type="checkbox"/> Shingles | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Hepatitis A,B,C | <input type="checkbox"/> Smoke | <input type="checkbox"/> Others _____ |
| <input type="checkbox"/> Cancer/ Tumors | <input type="checkbox"/> High/Low Blood
Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Stroke/Heart Attack | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems | |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis TB | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Epilepsy/ Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Venereal Disease | |

- Are you in general good health at this time? Yes No
If yes, please rate from 1-10: _____
- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Do you use tobacco? Yes No How used? _____ How much? _____ How long? _____
If yes, please explain: _____
- Have you ever had Novocaine anesthetic? Yes No
If yes, any reactions or allergic symptoms, please explain: _____
- Have you ever taken the drug Phen-fen and or Redux? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Are you taking medication? Yes No (Herbs, Vitamins, Aspirin)
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____