Patient Name

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   if yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Implant/Cosmetic Surgery	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	Venereal Disease	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough	Yes	No	Blood Transfustion	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Hemophillia/Sickle Cell Disease	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Rhuematic Fever	Yes	No	Hay Fever	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Arthritis/Rheumatism	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious/Stress	Yes	No
Kidney Trouble	Yes	No	Chemotherapy	Yes	No	Psychiatric/Physcological Care	Yes	No
History of/or currently Snore	Yes	No	Tumors	Yes	No	Migraines or Headaches	Yes	No
Daytime drowsiness	Yes	No	Sleep Apnea	Yes	No			

7. Do you require an antibiotic prior to dental treatment? ..... Yes No
8. Do you use more than two pillows to sleep? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list _____
10. Women : Are you preganant ? Yes, _____months No Nursing ? Yes No Taking birth control pills ?Yes No

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

History Review

Doctor Signature _____ Date _____