MEDICAL DENTAL HISTORY FORM

Patient Name: _____ Date of Birth _____ Sex: M/F
Medical Clinic and Location _____
Physician Name and Number: _____
Are you currently being treated by a Physician? Yes _____ No _____
If so, please list all conditions: _____
List Illnesses/Surgeries/Hospitalizations in the last 5 years:
_____

Current Medications (Prescription, Over the Counter and Herbal)

Medication	Dosage	Frequency		Medication	Dosage	Frequency

Allergies To:
Latex: Yes No
Medications _____
Anesthetic _____
Other _____

PREMEDS
Required: Yes No
Antibiotic _____
Dosage _____

Past and Current Medical conditions (Please circle yes or no)

Women: Pregnant	Y	N	Lung Disease	Y	N	Tobacco use	Y	N
Women: Nursing	Y	N	Emphysema	Y	N	Fainting/Dizziness	Y	N
Oral Contraceptives	Y	N	Shortness of Breath	Y	N	Headaches	Y	N
Heart Trouble/Disease	Y	N	Tuberculosis	Y	N	Depression: diagnosed	Y	N
Heart Surgery	Y	N	Asthma	Y	N	Psychiatric Disorder	Y	N
Chest Pain	Y	N	Sleep Apnea	Y	N	Neurological Disease	Y	N
Stroke	Y	N	Sinus Problems	Y	N	Convulsions	Y	N
Rheumatic Fever	Y	N	Strep Throat	Y	N	Epilepsy/Seizures	Y	N
Past Use of Fenphen	Y	N	Tonsillitis	Y	N	Cerebral Palsy	Y	N
Heart Murmur	Y	N	Cancer	Y	N	Multiple Sclerosis	Y	N
Artificial Heart Valve	Y	N	Radiation to Head/Neck	Y	N	Sjogrens Disease	Y	N
Endocarditis	Y	N	Chemotherapy	Y	N	Fibromyalgia	Y	N
CongenitalHeartDisease	Y	N	Kidney Disease	Y	N	Arthritis	Y	N
Heart Transplant	Y	N	Dialysis	Y	N	Drug Use	Y	N
Pacemaker/Defibrillator	Y	N	Eating Disorder	Y	N	AIDS/HIV Positive	Y	N
Joint Replacement	Y	N	Acid Reflux	Y	N	Hepatitis	Y	N
Organ Transplant	Y	N	Ulcers	Y	N	Alcohol/Drug dependent	Y	N
High/LowBlood Pressure	Y	N	Immunological Disease	Y	N	Thyroid Disease	Y	N
Blood Disease	Y	N	Hemophilia	Y	N	Liver Conditions	Y	N
Diabetes	Y	N	Anemia	Y	N	Glaucoma	Y	N
Type:___ Controlled	Y	N	Cold Sores	Y	N	Blood Transfusion	Y	N
Other:_____	Y	N						

Patient Signature: _____ Today's Date: _____
(Parent sign if child is a minor)