

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
Congenital Heart Disease	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/Low Blood 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)