

# Medical History

Name \_\_\_\_\_ Date \_\_\_\_\_

1. Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_

2. Are you currently under physician's care? If yes, for what reason? \_\_\_\_\_ Yes No

3. Have you been hospitalized in the last 2 years? If yes, for what reason? \_\_\_\_\_ Yes No

4. Have you ever taken Fen-Phen / Redux? \_\_\_\_\_ Yes No

5. Are you sensitive or allergic to dental anesthetic or Latex? If yes, please specify: \_\_\_\_\_ Yes No

6. Please list your current medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Please list your drug allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Do you have or have ever had any of the following?

- |   |  |   |
|---|--|---|
| High Blood Pressure _____ Yes No<br>Angina Pectoris _____ Yes No<br>Stroke _____ Yes No<br>Heart Disease _____ Yes No<br>Heart Attack _____ Yes No<br>Heart Surgery _____ Yes No<br>Heart Pacemaker _____ Yes No<br>Artificial Heart Valve _____ Yes No<br>Mitral Valve Prolapse _____ Yes No<br>Heart Murmur _____ Yes No<br>Rheumatic Fever _____ Yes No<br>Artificial Joints _____ Yes No<br>Arthritis or Rheumatism _____ Yes No<br>Osteoporosis _____ Yes No | Allergies or Hives _____ Yes No<br>Sinus Problems _____ Yes No<br>Asthma _____ Yes No<br>Emphysema _____ Yes No<br>Tuberculosis _____ Yes No<br>Diabetes _____ Yes No<br>Thyroid Problems _____ Yes No<br>Kidney Disease _____ Yes No<br>Ulcers _____ Yes No<br>Cancer or Tumor _____ Yes No<br>Radiation or Chemotherapy _____ Yes No<br>Epilepsy or Seizures _____ Yes No<br>Fainting or Dizzy Spells _____ Yes No<br>Nervousness _____ Yes No | Hepatitis _____ Yes No<br>Venereal Disease _____ Yes No<br>A.I.D.S. or H.I.V. Positive _____ Yes No<br>Blood Transfusion _____ Yes No<br>Hemophilia _____ Yes No<br>Anemia _____ Yes No<br>Sickle Cell Disease _____ Yes No<br>Bruise Easily _____ Yes No<br>Liver Disease _____ Yes No<br>Yellow Jaundice _____ Yes No<br>Cold Sores or Fever Blisters _____ Yes No<br>Cortisone Medication _____ Yes No<br>Drug Addiction _____ Yes No<br>Cigarettes _____ 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 ONLY: Are you pregnant? \_\_ Yes No / What Month? \_\_ / Nursing? \_\_ Yes No / Are you taking birth control pills? \_\_ Yes No

I understand the above information is accurate to the best of my knowledge and is necessary to provide me with dental care in a safe and efficient manner. I will inform the doctor of any change in my medical status.

I authorize the doctor to perform recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated by such treatment.

I authorize my insurance company to pay the dentist all benefits otherwise payable to me for services rendered. I authorize the use of my social security number and my signature on my dental insurance claims.

I understand payment is due in full at time of treatment unless prior arrangements have been approved.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History Updates

Date	Please note any changes since you last filled out this form	Patient Signature	Doctor Review
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____