

Patient Name: _____

MEDICAL HISTORY

Have you been under the care of a doctor during the last two years? Yes No

If yes, for what? _____

Physician Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Have you taken any medication or drugs during the past two years? Yes No

If yes, please list name and dosage: _____

Are you aware of having an allergic (or adverse reaction) to any medication of substance: Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years? Yes No

Indicate which of the following you have had, or have at present.
PLEASE CIRCLE "YES" OR "NO" TO EACH ITEM

Heart (Surgery, Disease, Attack).....	Yes	No	Ulcers.....	Yes	No	Venereal Disease.....	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	A.I.D.S.....	Yes	No
Congenital Heart Disease.....	Yes	No	Kidney Trouble.....	Yes	No	HIV Positive.....	Yes	No
Heart Murmur.....	Yes	No	Thyroid Problems.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Glaucoma.....	Yes	No	Blood Transfusion.....	Yes	No
Artificail Heart Valve.....	Yes	No	Contact Lenses.....	Yes	No	Hemophilia.....	Yes	No
Heart Pacemaker.....	Yes	No	Emphysema.....	Yes	No	Sickle Cell disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Chronic Cough.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Tuberculosis.....	Yes	No	Liver Disease.....	Yes	No
Hepatitis A (infectious), B (serum).....	Yes	No	Asthma.....	Yes	No	Yellow Jaundice.....	Yes	No
Cortisone Medication.....	Yes	No	Hay Fever.....	Yes	No	Neurological Disorders.....	Yes	No
Swollen Ankles.....	Yes	No	Latex Sensitivity.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Stroke.....	Yes	No	Allergies or Hives.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Tumor/Cancer.....	Yes	No	Nervous/Anxiety Disorder.....	Yes	No
Artificial Joints (Hip, Knee, etc).....	Yes	No	Radiation Therapy.....	Yes	No	Psychiatric/Psychological Care.....	Yes	No
Artificial Breast Implants.....	Yes	No	Chemo-Therapy.....	Yes	No	Sinus Trouble.....	Yes	No

Do you have or have you had any disease, condition or problem not listed above?..... Yes No

If yes, Please list: _____

Do you use more than two pillows to sleep? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

WOMEN: are you Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No Are your periods regular? 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 contact the respective health care provider or agency who may release such information to you. I will notify Doctor Tamura of any changes in my health or medications.

Patient/Guardian Signature: _____ Date: _____

History Review

Doctor Signature: _____ Date: _____