

Blackstone Valley Dental Associates

MEDICAL HISTORY

Patient Name (please print) _____

Medical Alert (office use only) _____

1. Name of your primary care physician _____ Phone # _____
Address _____ City _____ Zip _____
Name of specialist (if applicable) _____ Phone # _____
Address _____ City _____ Zip _____

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

3. Are you taking any medication, drugs or pills now including blood thinners or aspirin therapy? Yes No
If yes list name, dosage and reason for medication:

4. Are you aware of having any allergic (or adverse reaction) to any medication or substance? Yes No
If yes, please list: _____

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	Artificial Joints (hip, knee, etc. Yes No	Chemotherapy Yes No
Chest Pain Yes No If premed needed list prescription name & name of pharmacy and location _____	Tumors Yes No
Congenital Heart Disease Yes No		Hepatitis A (infectious) B (serum) Yes No
Heart Murmur Yes No		Venereal Disease Yes No
.... If premed needed list prescription name & name of pharmacy and location _____		A.I.D.S. Yes No
	Kidney Trouble Yes No	H.I.V. Positive Yes No
	Ulcers Yes No	Cold Sores / Fever Blisters Yes No
	Thyroid Problems Yes No	Blood Transfusion Yes No
High Blood Pressure Yes No	Glaucoma Yes No	Hemophilia Yes No
Mitral Valve Prolapse Yes No	Contact Lenses Yes No	Sickle Cell Disease Yes No
Artificial Heart Valve Yes No	Emphysema Yes No	Bruise Easily Yes No
Heart Pacemaker Yes No	Chronic Cough Yes No	Liver Disease Yes No
Rheumatic Fever Yes No	Tuberculosis Yes No	Yellow Jaundice Yes No
Arthritis / Rheumatism Yes No	Asthma Yes No	Neurological Disorders Yes No
Cortisone Medication Yes No	Hay Fever Yes No	Epilepsy or Seizures Yes No
Swollen Ankles Yes No	Latex Sensitivity Yes No	Fainting or Dizzy Spells Yes No
Stroke Yes No	Allergies or Hives Yes No	Nervous / Anxious Yes No
Diet (Special / Restricted) Yes No	Sinus Trouble Yes No	Psychiatric / Psychological Care Yes No
Diabetes Yes No	Radiation Therapy Yes No	

7. Can you be reclined in a dental chair? Yes No
If no, do you need head or back support? Yes No

8. Do you have or have you had any disease, condition or problem not listed? Yes No
If yes, please list: _____

9. Women: are you Pregnant? 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 healthcare 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 (Office Use Only)

Heart:

Hypertension:

Meds:

Hospital:

Allergy:

Physician:

Pregnancy:

Other:

Providers Signature _____ Date _____