MEDICAL HISTORY

PATIENT NAME_____DATE_____

Please check mark appropriately any conditions which you have had in the past or have now. (Parents and Guardians) If you are completing this form for your child or a minor, please indicate their appropriate health responses.

CARDIOVASCULAR

Heart Failure	()
Heart Disease or Attack	()
Angina Pectoris or Chest pain	()
High Blood Pressure	()
Heart Murmur	()
Mitral Valve Prolapse	()
Rheumatic Fever	()
Congenial Heart Defect or Lesion	()
Artificial Heart Valve	()
Arrhythmias	()
Heart Pacemaker or Defibrillator	()
Heart Surgery or Transplant	()
Other Heart problems	()
Stroke	()
Aneurysm	()

HEMATOLOGIC

Blood Transfusion	()
Anemia	()
Hemophilia	()
Leukemia	()
Sickle Cell Anemia	()
Tendency to bleed longer	()

NEURAL/SENSORY

Eye Pain	()
Vision Problems	()
Glaucoma	()
Earaches, ringing in ears	()
Hearing Loss	()
Severe headaches	()
Fainting or dizzy spells	()
Epilepsy, seizures or convulsions	()

GASTROINTESTIONAL

Stomach/intestinal Ulcer	()
Gastritis	()
Colitis	()
Persistent Diarrhea	()
Hepatitis	()
Liver Disease	()
Yellow Jaundice	()
Cirrhosis	()

RESPIRATORY

Hay Fever	()
Sinus trouble	()
Allergies or hives	()
Asthma	()
Chronic cough	()
Emphysema	()
Tuberculosis	()
Breathing difficulties	()

DERMAL/MC/MS

Allergy to Latex (Rubber)	()
Skin Rash	()
Dark moles (recent changes in appearance)	()
night sweats	()
Sore muscles	()
Stiff joints	()
Arthritis	()
Artificial joints	()
Fever Blister, cold sore	()
Mouth ulcers or canker sores	()
Colored or discolored areas in the mouth	()

ENDOCRINE

Diabetes	()
Thyroid Disease	()

UNINARY/ST

Urinate frequently	()
Kidney Bladder problem	()
Sexually transmitted diseases (syphilis, Gonorrhea, Chlamydia or genital herpes)	()
HIV positive	()

OTHER CONDITIONS

Frequent sore throats	()
Enlarged Lymph nodes or glands	()
Use tobacco	()
Use alcohol	()
Drug or alcohol addiction	()
(recovering or current)	()
Tumor or cancer	()
x-ray or Cobalt treatment	()
Chemotherapy	()
Disease, problem, or condition	()
not listed here, if yes please list	()

_____
_____
_____

Please complete the reverse side also. Thank you

- Are you currently under the care of a physician Yes or No
- Physician's
  Name_____Address_____
  Phone number_____ Last appointment date _____
  Reason_____
- Are you taking or supposed to be taking any medications, drugs, or pills of any kind? Yes or No
  If yes, what kind and dosage
  _____
- Have you taken Cortisone or other steroids in the past 12 months Yes or No
- Do you have reactions or allergies to drugs or medicines Yes or No
- If yes, _____
- Have you had a reaction to dental or general anesthetic Yes or No
- Have you ever had any operations or surgery Yes or No
  Describe the problem and any complications _____
- Have you ever been hospitalized Yes or No
- When you walk up stairs or take walk, do you ever have to stop because of pain in your chest , shortness of breath or because you are very tired? Yes or No
- Do your ankles swell during the day? Yes or No
- Do you sleep on two or more pillows Yes or No
- Have you unintentionally lost or gained more than 10 pounds in the past year Yes or No
- Are you on a special diet Yes or No
- Does your occupation bring you into contact with blood, blood products or needles Yes or No
- (WOMEN) Are you pregnant Yes or No
- Have you ever been treated for periodontal disease Yes or No

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have a change in my health, abnormal laboratory test, or if my medications change, I will inform the dentist at the next appointment without fail.

Date _____ Patient/Guardian Signature_____

Date _____ Dentist Signature_____

Review and Update

Date _____ Signature _____ Changes in Health Status _____
Date _____ Signature _____ Changes in Health Status _____
Date _____ Signature _____ Changes in Health Status _____

Height _____ Weight _____ BP _____ Pulse _____ Resp _____ Temp _____

Health Comments and Summary : ASA I II III IV

_____
_____