MEDICAL HISTORY

Patient Name	Medical Alert

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____

Physician's name and address _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No _____

Do you use tobacco? ○ Yes ○ No If yes, how many: _____

Do you use controlled substances? ○ Yes ○ No _____

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Diabetes ○ Yes ○ No	Hemophilia ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Easily Winded ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Anemia ○ Yes ○ No	Emphysema ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatism ○ Yes ○ No
Angina ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Asthma ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Gerd/Reflex ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Hay Fever ○ Yes ○ No	Osteoporsis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Pace Maker ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Cortisone Medicine ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

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 health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

MEDICAL UPDATES (Staff use) **Note changes, date and sign.**

Date ☐ no change ☐ see notes	Date ☐ no change ☐ see notes	Date ☐ no change ☐ see notes
Date ☐ no change ☐ see notes	Date ☐ no change ☐ see notes	Date ☐ no change ☐ see notes
Date ☐ no change ☐ see notes	Date ☐ no change ☐ see notes	Date ☐ no change ☐ see notes