Medical History

_____
Patient name

1. Have you been under the care of a medical doctor during the past two years? Yes___No___
   If yes, for what?_____
   Physician's name_____ Phone_____
   Address_____

2. Please list any medications, drugs or pills you are now taking.
   _____
   _____

3. Please list any allergies or medications that have caused allergic reactions.
   _____
   _____

4. Indicate which of the following you have had, or have at present. (circle one)

Heart (Surgery, Disease, Attack)……	Yes	No	Asthma……	Yes	No
Chest Pain……	Yes	No	Latex Sensitivity……	Yes	No
Congenital Heart Disease……..	Yes	No	Allergies or Hives….....	Yes	No
Heart Murmur…….....	Yes	No	Sinus Trouble…….. ……	Yes	No
High Blood Pressure…….....	Yes	No	Radiation Therapy……..	Yes	No
Mitral Valve Prolapse……..	Yes	No	Chemotherapy…….	Yes	No
Artificial Heart Valve…….	Yes	No	Tumors…….....	Yes	No
Heart Pacemaker……...	Yes	No	Hepatitis……	Yes	No
Rheumatic Fever……..	Yes	No	If yes, A, B or C		
Arthritis/Rheumatism……	Yes	No	A.I.D.S. ……	Yes	No
Cortisone Medication……	Yes	No	H.I.V. positive……..	Yes	No
Stroke…….	Yes	No	Hemophilia…….....	Yes	No
Diet (Special/Restricted)…….	Yes	No	Liver Disease……	Yes	No
Artificial Joints (Hip, Knee, etc)……..	Yes	No	Yellow Jaundice…….....	Yes	No
Kidney Trouble……	Yes	No	Neurological Disorders……...	Yes	No
Ulcers……	Yes	No	Epilepsy or Seizures……..	Yes	No
Diabetes……	Yes	No	Fainting or Dizzy Spells…….	Yes	No
Thyroid Problems…….	Yes	No	Nervous/Anxious…….	Yes	No
Tuberculosis…….	Yes	No	Psychiatric/Psychological……..	Yes	No

5. Please list any disease, condition or problem not mentioned above.
   _____

6. List any issues you have with sleep apnea. (snoring, restless or interrupted sleep patterns, feel tired after a full night's sleep, use a sleep appliance or machine)
   _____
   _____

7. **Women:** Are you: **Pregnant?** Yes___Months No **Nursing?** Yes No
   Taking birth control pills? Yes No

I understand that 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 any change in my health or medication.

Patient/Guardian Signature_____**Date**_____