PATIENT NAME_____

DATE_____

MEDICAL HISTORY: Please Circle:

Are you presently under a physician's care? For what reason?_____ Yes No

Name of Physician:_____Phone # (if known)_____

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

Have you ever had a serious injury to your head or neck? If yes, please discuss:_____ Yes No

Are you taking medications, pills, herbal, or drugs? What?_____ Yes No

_____

_____

_____

_____

Are you allergic to any medications or substances? Please check box below

☐Aspirin ☐Penicillin ☐Codeine ☐Metals ☐Latex Rubber ☐Anesthetic ☐Other_____

WOMEN (Please Check) ☐Pregnant ☐Trying to get Pregnant ☐Nursing ☐Taking oral contraceptives

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Trouble/Dis.	☐	☐	Excessive Bleeding	☐	☐	Ulcers	☐	☐	Genital Herpes	☐	☐
Angina/Chest Pain	☐	☐	Lung Disease	☐	☐	Kidney Problems	☐	☐	Oral Herpes	☐	☐
Heart Attack/Failure	☐	☐	Breathing Problems	☐	☐	Diabetes	☐	☐	Cold Sores	☐	☐
Stroke/Vascular Dis.	☐	☐	Cough	☐	☐	Hypoglycemia	☐	☐	Alcoholism	☐	☐
Heart Murmur*	☐	☐	Allergies	☐	☐	Liver Dis.	☐	☐	Drug Addiction	☐	☐
Mitral Valve Prolapse*	☐	☐	Hives or Rash	☐	☐	Hepatitis A	☐	☐	Epilepsy or Seizures	☐	☐
Heart Pacemaker*	☐	☐	Sinus Trouble	☐	☐	Hepatitis B or C	☐	☐	Parkinson's Dis.	☐	☐
Heart Surgery*	☐	☐	Asthma	☐	☐	Yellow Jaundice	☐	☐	Fainting or Dizziness	☐	☐
Rheumatic Fever*	☐	☐	Emphysema	☐	☐	Thyroid Disease	☐	☐	Glaucoma	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Arthritis/Gout	☐	☐	Tumors or Growths	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Pain in Jaw Joints	☐	☐	Depression	☐	☐
Blood Disease	☐	☐	X-ray Trmt. (Rad)	☐	☐	Artificial Joint*	☐	☐	Alzheimer's Dis.	☐	☐
Bruise Easily	☐	☐	Chemotherapy	☐	☐	Venereal Disease	☐	☐	Hearing Loss	☐	☐
Anemia	☐	☐	Stomach/Intestinal Dis.	☐	☐	AIDS/HIV Positive	☐	☐	Difficulty Swallowing	☐	☐

Have you ever had any other serious illness, disease, or condition not listed above? Yes No

If yes, please discuss:_____

Do you wish to talk to the dentist privately about any problems or concerns? Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my

medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____

_____

PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

Reviewed by_____

Date:_____

History Review and Significant

Findings:_____

_____

_____

MEDICAL UPDATES:

I have read my Medical History dated _____and confirm that it adequately states past and

Present conditions Date	Changes	Patient's Signature	Reviewed By: