Preventive • Restorative • Cosmetic • Dentistry

Medical history for:

Patient Name _____ **Nickname**_____ **Date of Birth** _____

Are you allergic to any of the following?

Latex___ Penicillin___ Amoxicillin___ Aspirin___ Ibuprofen___ or any reaction to a substance or medication not listed? _____

Have you ever had a reaction after receiving dental anesthetic? Yes ___ No___

Explain reaction:_____

HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST YEAR? YES ___ NO ___

For What Condition? _____

Please check yes or no to the following medical conditions & date when the condition occurred:

	Yes	No	Date		Yes	No	Date
Heart Attack	___	___	_____	Cancer / Tumors	___	___	_____
Stroke	___	___	_____	Chemotherapy	___	___	_____
Heart Surgery	___	___	_____	Radiation Treatment	___	___	_____
Angina / Chest Pain	___	___	_____	Leukemia	___	___	_____
Heart Murmur	___	___	_____				
Pacemaker / Defibrillator	___	___	_____	Artificial Joints	___	___	_____
Congenital Heart Defect	___	___	_____	Arthritis	___	___	_____
Artificial Valves	___	___	_____	Rheumatism	___	___	_____
Mitral Valve Prolapse	___	___	_____	Jaw Problems / TMJ	___	___	_____
High / Low Blood Pressure	___	___	_____				
				Bleeding Problems	___	___	_____
Allergies	___	___	_____	Diabetes / Hypoglycemia	___	___	_____
Asthma	___	___	_____	Hepatitis	___	___	_____
Breathing Problems	___	___	_____	Kidney Disease	___	___	_____
Respiratory Disease	___	___	_____	Liver Disease	___	___	_____
Sinus Problems	___	___	_____	Rheumatic Fever	___	___	_____
Tuberculosis TB	___	___	_____	Scarlet Fever	___	___	_____
				Shingles	___	___	_____
Eating Disorders	___	___	_____	Thyroid Problems	___	___	_____
Drug / Alcohol Abuse	___	___	_____	Herpes	___	___	_____
Tobacco Use	___	___	_____	Venereal Disease	___	___	_____

Please list any medical conditions you have ever had that are not listed above:

_____

_____

Please list any medications you are currently taking (including herbal medications):

_____

_____

Have you ever taken the drug Phen-fen or Redux? Yes___ No___

Please rate your general health from 1 to 10 (with 10 being the healthiest)____

Are you pregnant? Yes ___ No___

Signature_____(if parent or guardian, please circle) Date _____

MEDICAL HISTORY UPDATE - Please list any changes since last visit:

MEDICINE	MEDICAL CONDITION	DATE OF CHANGE	SIGNATURE & DATE