

1. Physician's name \_\_\_\_\_ ( ) \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Address \_\_\_\_\_

2. Approximate date of your last doctor's visit? \_\_\_\_\_

3. Are you currently under the care of a physician? **N Y**  
 If yes, please explain \_\_\_\_\_

4. Are you taking any medication? **N Y**  
 If yes, please list \_\_\_\_\_

5. Have you ever had any serious illness or surgery? **N Y**  
 If yes, please explain \_\_\_\_\_

6. For women: Are you pregnant? **N Y**  
 Date Due \_\_\_\_\_

Do you use birth control medications? **N Y**

7. Are you allergic or have you reacted adversely to any of the following medications? **N Y**

Penicillin	<b>N Y</b>	Tetracycline	<b>N Y</b>
Erythromycin	<b>N Y</b>	Codeine	<b>N Y</b>
Aspirin	<b>N Y</b>	Dental Anesthetics	<b>N Y</b>

Are you allergic to any other medications?  
 If yes, please list \_\_\_\_\_

8. Have you ever had any of the following medical problems?

Allergies/ Asthma	<b>N Y</b>	Cancer	<b>N Y</b>
Heart Attack/ Stroke	<b>N Y</b>	Chemo/ radiation therapy	<b>N Y</b>
Heart Murmur/ Rheumatic Fever	<b>N Y</b>	HIV+/ AIDS	<b>N Y</b>
Prolapse mitral valve	<b>N Y</b>	Kidney Problems	<b>N Y</b>
Heart Surgery/ pacemaker	<b>N Y</b>	Diabetes	<b>N Y</b>
High/ low blood pressure	<b>N Y</b>	Tuberculosis	<b>N Y</b>
Anemia/ blood disorder	<b>N Y</b>	Psychiatric treatment	<b>N Y</b>
Hepatitis	<b>N Y</b>	Metal/ latex sensitivities	<b>N Y</b>
Epilepsy/ seizures/ fainting spells	<b>N Y</b>	Arthritis/ Rheumatism	<b>N Y</b>
Drug/ Alcohol abuse	<b>N Y</b>	Artificial joint/ prosthesis	<b>N Y</b>
Hemophilia/ abnormal bleeding	<b>N Y</b>	Venereal Disease	<b>N Y</b>
Liver Problems	<b>N Y</b>	Bulemia/ anorexia	<b>N Y</b>

9. Do you have any disease, condition or problem not listed?  
 If yes, please explain \_\_\_\_\_

10. Do you smoke or use tobacco in any form? **N Y**  
 If yes, are you interested in stopping this habit? **N Y**

11. Is there anything else we should know about your health that we have not covered in this form? **N Y**  
 If yes, please explain \_\_\_\_\_

office use only  
 comments

I certify that the Dental History & Medical History information is complete and accurate.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY