PATIENT MEDICAL HISTORY ***Patient Name _____ Date _____***

Physician _____ Office PH._____ Date of Last Exam _____

1. Are you under a physicians care now? _____ Explain _____
2. Have you ever been hospitalized or had a surgical procedure? ____ In the last 5 yrs? _____ Explain _____

   _____
3. Have you ever had a serious head or neck injury? _____ Explain _____
4. Have you ever taken, Phen-Fen, Redux, Boniva, Fosamax, Actonel or any cancer medications containing bisphosphonates?
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?
6. Are you on a special diet? _____Explain _____
7. Do you smoke? _____use tobacco? _____How often? _____
8. Do you use controlled substances? _____Frequency? _____
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasted more than 3 wks)?_____
10. Are you allergic to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

    Other _____, Explain _____
11. Are you taking medications (including non prescription medicines): _____ If yes, Please List: _____

    _____

    Ask for a separate sheet of paper if you need it.

Women: Are you : Pregnant/Trying to get pregnant? _____ Taking Oral Contraceptives? _____ Nursing? _____

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

○ High Blood Pressure	○ Heart Trouble	○ Chest Pains	○ AIDS or HIV Positive/Infection
○ Heart Attack/Failure/Disease	○ Cardiac Pacemaker	○ Easily Winded	○ Sexually Transmitted Disease
○ Rheumatic Fever	○ Heart Murmur	○ Stroke	○ Cold Sores/Fever Blisters
○ Artificial Heart Valve	○ Artificial Joint	○ Blood Disease	○ Alzheimer's Disease
○ Low Blood Pressure	○ Bruise Easily	○ Congenital Heart Disorder	○ Anaphylaxis
○ Cortisone Medicine	○ Herpes	○ Excessive Bleeding/Hemophilia	○ Thyroid Problem
○ Pain in Jaw Joints	○ Psychiatric Care	○ Radiation Therapy	○ Stomach Troubles/Ulcers
○ Chemotherapy	○ Renal Dialysis	○ Sickle Cell Disease	○ Hepatitis B or C
○ Spina Bifida	○ Tumors or Growths	○ Yellow Jaundice	○ Hepatitis A
○ Shingles	○ Irregular Heart Beat	○ Lung Disease	○ Kidney Diseases
○ Swollen Ankles	○ Angina	○ Hay Fever/Allergies	○ Joint Replacement or Implant
○ Fainting/Dizziness	○ Frequently Tired	○ Tuberculosis	○ Diabetes
○ Asthma	○ Anemia	○ Radiation Therapy	○ Liver Disease
○ Blood Transfusion	○ Emphysema	○ Glaucoma	○ Epilepsy/Seizures/Convulsions
○ Recent Weight Loss	○ Cancer	○ Leukemia	○ Arthritis

Have you had any serious illness not listed above? _____

Comments:_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

_____
Signature of patient (or parent/guardian if minor) Date

Doctors Comments: _____

_____

_____

_____Doctor Signature_____Date _____