

MEDICAL HISTORY

MEDICAL ALERT

Patient Name _____

Patient Birth Date _____

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 _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you taking any medication, drugs or pills now? Yes No

If yes, please list name and dosage _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Veneral Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

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

8. Do you use tobacco? Yes _____ No _____ How much? _____

9. Have you lost or gained more than 10 pounds in the past year? Yes No

10. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please discuss _____

11. Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge, all of 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 _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ 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	EXCEPTIONS	NONE <input type="checkbox"/>	PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	<input type="checkbox"/>	_____	DR. _____
_____	_____	<input type="checkbox"/>	_____	DR. _____
_____	_____	<input type="checkbox"/>	_____	DR. _____
_____	_____	<input type="checkbox"/>	_____	DR. _____
_____	_____	<input type="checkbox"/>	_____	DR. _____
_____	_____	<input type="checkbox"/>	_____	DR. _____