



Medical History

Patient Name _____	Medical Alert (Office Use Only) _____
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Address _____ City _____ Postal Code _____

Phone (home) _____ (cell) _____ Sex M F Age _____ Birth Date ____/____/____
month day year

Adult Patient

Occupation _____

Employer _____

Phone (work) _____

Email _____

Marital Status M S W D

Dental Insurance No Yes AHC# _____

How did you find about our office? Friend Name _____ Phonebook (Yellow Pages) (Local Directory)

Newspaper Flyer Internet Website _____ Other Please Specify _____

What is your preferred method of contact? Phone Text Email

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 _____

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

If yes, please list the name and dosage _____

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

If yes, please list _____

4. Have you been hospitalized in the past five years? Yes No

5. Indicate which of the following you have had, or presently have

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

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

If yes, please list _____

7. Women Are you: **Pregnant?** Yes ___ Months No **Nursing?** Yes No **Taking Birth Control Pills** Yes No

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the representative health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date ____/____/____
month day year

