# MEDICAL HISTORY

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 _____

Have you been a patient in the hospital during the past five years? If yes, why? _____

Are you a ware of having an allergic or adverse reaction of any medication or substance? _____

Are you currently taking medication? If yes, what is the name and dosage? _____

Have you had any surgeries in the last five years? _____

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

| | | | | | |
|---|---|---|---|---|---|
| Heart surgery | YES NO | Artificial joint | YES NO | Do you see a cardiologist | YES NO |
| A-Fib | YES NO | Swollen ankles | YES NO | Been Prescribed bisphosphonates | YES NO |
| Cardiac stents | YES NO | Spine Injuries | YES NO | A.I.D.S | YES NO |
| Chest Pain | YES NO | Restricted diet | YES NO | H.I.V positive | YES NO |
| Congenital Heart Disease | YES NO | Ulcers | YES NO | Hepatitis A or B | YES NO |
| Heart murmur | YES NO | Glaucoma | YES NO | Been prescribed methotrexate | YES NO |
| High Blood Pressure | YES NO | Chronic cough | YES NO | Any anesthesia complications | YES NO |
| Mitral Valve Prolapse | YES NO | Tuberculosis | YES NO | Sleep Apnea | YES NO |
| Artificial Heart Valve | YES NO | Asthma | YES NO | GERD/Acid reflux | YES NO |
| Heart Pacemaker | YES NO | High fever | YES NO | Shortness of breath | YES NO |
| Rheumatic fever | YES NO | Latex sensitivity | YES NO | Psychiatric/psychological care | YES NO |
| Arthritis Rheumatism | YES NO | Allergies or hives | YES NO | Nervous or anxious | YES NO |
| Stroke | YES NO | Sinus trouble | YES NO | Neurological disorders | YES NO |
| Kidney Trouble | YES NO | Radiation therapy | YES NO | Tetracycline staining | YES NO |
| Diabetes | YES NO | Chemotherapy | YES NO | Pain management contract | YES NO |
| Thyroid Problems | YES NO | Bruise easily | YES NO | Dry mouth | YES NO |
| Tumors | YES NO | Cold sores/fever blisters | YES NO | Hyperactive gag reflex | YES NO |
| Hemophilia | YES NO | Fainting/dizzy spells | YES NO | Sleep with more than two pillows | YES NO |
| Sickle Cell Disease | YES NO | Blood transfusions | YES NO | Lost or gained more than 10 pounds | YES NO |
| Epilepsy or Seizures | YES NO | Liver Disease | YES NO | Face pain related to a tooth | YES NO |

Women: Are you pregnant: YES, ____months NO Nursing? YES NO Taking birth control pills? YES NO

I understand that the above information is necessary to provide me with dental care in a safe and 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 respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

*Patients/Guardian's Signature: _____ Date: _____

History Review

Dentist Signature: _____ Date: _____