MEDICAL HISTORY

Patients Name_____

Date of Last Dental Visit: _____ Reason for **TODAYS** visit: _____

Do you have or have you ever had any of the following:

Aids / HIV	Y	N	Heart Murmur	Y	N	Rheumatic Fever	Y	N
Anemia	Y	N	Mitral Valve Prolapse	Y	N	Stomach Problems	Y	N
Arthritis	Y	N	Hepatitis	Y	N	Ulcers	Y	N
Artificial Joints	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N	Tuberculosis	Y	N
Blood Thinners	Y	N	Jaundice	Y	N	Tumors/Growths	Y	N
Cancer	Y	N	Mental Disorders	Y	N	Tobacco User	Y	N
Coumadin	Y	N	Nervous Disorders	Y	N	Staph/MRSA	Y	N
Diabetes	Y	N	Pacemaker	Y	N			
Dizziness/Fainting	Y	N	Currently Pregnant	Y	N			
Epilepsy/seizures	Y	N	Radiation Treatment	Y	N			
Excessive Bleeding	Y	N	Respiratory Problems	Y	N			
Head Injuries	Y	N	Rheumatism	Y	N			

Are you allergic to any of the following listed below? If yes, please circle

IODINE CODEINE FOOD LATEX PENICILLIN PREDNISONE SEASONAL SULFA
OTHER _____

Please list all *MEDICATIONS* you are currently taking:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____