____

MEDICAL HISTORY

Patient Name

1. Have you been under the care of a medical doctor during the past two years? Yes No
2. If yes, for what? ____
   Physician's Name __________________________ Phone ______________
   Address ______________________________ City__________ State ____
3. Have you taken any medication or drugs during the past two years? Yes No
   If yes, please list name and dosage ___________________________________
   ____
   ____
4. Are you taking any medication for osteoporosis? Yes No
5. Are you aware of having an allergic or adverse reaction to any medication? Yes No
   If yes, please list ____
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each.

Yes	No	Heart disease, or heart attack	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) or B Serum
Yes	No	Chest pain	Yes	No	Diabetes	Yes	No	Venereal disease
Yes	No	Congenital heart disease	Yes	No	Thyroid problems	Yes	No	AIDS
Yes	No	Heart murmur	Yes	No	Glaucoma	Yes	No	HIV 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 / hives	Yes	No	Neurological disorders
Yes	No	Stroke	Yes	No	Sinus trouble	Yes	No	Epilepsy / 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 problems	Yes	No	Tumors	Yes	No	Psychiatric / psychological

8. Do you have sleep apnea? Do you snore or use a snoreguard? Yes No
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 list ____
11. **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 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 any change in my health or medication.

Patient / Guardian Signature ______________________________ Date ________________