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Cosmetic & Family Dentistry

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MEDICAL HISTORY

Patient's Name _____ Person Completing Form _____

Medical Alert _____

Physician's Name _____ Phone # _____

Have you had any medical care within the past two years? ☐Yes ☐No

If yes, please describe _____

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

If yes, please list names and dosage _____

Have you ever taken prescription medications for weight loss (diet pills)? ☐Yes ☐No

If yes, did you take any of the following? _____

If yes to any of the above, did you have a medical exam for heart issues? ☐Yes ☐No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs? ☐Yes ☐No

Are you aware of having a allergic (or adverse) reaction to any substance or medication? ☐Yes ☐No

If yes, please specify _____

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

Indicate which of the following you have had, or have at present

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

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

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

If yes, please list _____

Women: Are you pregnant or think you could be pregnant? ☐Yes ☐No _____ Months **Nursing?** ☐Yes ☐No

Do you use birth control prescriptions? ☐Yes ☐No

I understand the above information is necessary to provide me with the 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 _____

History Review

Dentist Signature _____ Date _____