MEDICAL HISTORY

1. Have you ever been under the care of a medical doctor during the past 2 years? Yes ☐ No ☐
   If yes, for What? ______________________________
   Physician's Name ________ Phone ________ City ________ State _____
2. Have you taken any medication or drug during the past 2 years? Yes ☐ No ☐
3. Are you taking any medication, drugs, or pills now? Yes ☐ No ☐
   If yes, list name and dosage? ______________________________
4. Are you allergic to or have you had adverse reaction to the following:

Local Anesthetics (i.e. Novocaine)	Yes ☐	No ☐	Sulfa Drugs	Yes ☐	No ☐	Barbiturates	Yes ☐	No ☐
Penicillin or any other Antibiotics	Yes ☐	No ☐	Sedatives	Yes ☐	No ☐	Iodine	Yes ☐	No ☐
Any Metals (i.e. nickel, mercury etc.)	Yes ☐	No ☐	Latex Rubber	Yes ☐	No ☐	Aspirin	Yes ☐	No ☐

   Other ______________________________
5. Have you been a patient in the hospital during the past 5 years? Yes ☐ No ☐
   If yes, for What? ______________________________
6. Indicate which of following you have had or have at the present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack) …	Yes	No	Ulcers ………………….……..	Yes	No	Hepatitis ……………..…. …….	Yes	No
Chest Pain…………………………	Yes	No	Diabetes…………..	Yes	No	Sexually Transmitted Diseases	Yes	No
Congenital Heart Disease…………..	Yes	No	Thyroid Problems………. .	Yes	No	A.I.D.S…………………….………	Yes	No
Heart Murmur………………………	Yes	No	Glaucoma………………..	Yes	No	H.I.V. 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	Neurological Disorders ………..	Yes	No
Swollen Ankles ……………………	Yes	No	Allergies or Hives ……..	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	Sensitivity to dental anesthetic	Yes	No
Implants (Physical or Dental) …….	Yes	No	Antibiotics before dental treatment ………………………….……….				Yes	No

7. Do you use more than 2 pillows to sleep? Yes ☐ No ☐
8. Have you lost or gained more than 10 pounds in the past year? Yes ☐ No ☐
9. Do you have or had any disease, condition, or problem not listed? Yes ☐ No ☐
   If yes, Please list: ______________________________
10. Women: Are you: Pregnant? Yes ☐ 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.

X - Patient/Guardian Signature ______________________________ X - Date ________________

Doctor's Comments / History Review

Doctor's Signature ______________________________ Date ____________________