Patient Name	DOB	MEDICAL HISTORY
Medical Alert	PREFERRED TO BE CALLED	

Welcome! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

1. 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 _____
   When was the last time you saw your physician? _____
2. Have you taken any medications or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Have you taken prescription medications for Osteoporosis? (Fosamax, Boniva, Actonel, Zometa) ..... Yes No
   If yes, how long have you been taking it? _____
5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... 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 item.

Cosmetic Surgery	Yes No	Diabetes	Yes No	A.I.D.S. or H.I.V. Positive	Yes No
Heart (Surgery, Disease, Attack)	Yes No	Thyroid Problems	Yes No	Drug Abuse/Addiction	Yes No
Chest Pain	Yes No	Glaucoma	Yes No	Alcoholism	Yes No
Congenital Heart Disease	Yes No	Contact Lenses	Yes No	Pain in Jaw Joints	Yes No
Heart Murmur	Yes No	Emphysema	Yes No	Recreational Drug Use	Yes No
High Blood Pressure	Yes No	Chronic Cough	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Asthma	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Hay Fever	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Latex Sensitivity	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Allergies or Hives	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Sinus Trouble	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Radiation Therapy	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Chemotherapy	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/Restricted)	Yes No	Tumors/Growths	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Heart Failure, Angina, Anemia	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Hepatitis A (infectious) B (serum)	Yes No	Psychiatric/Psychological Care	Yes No
Ulcers	Yes No	Venereal Disease	Yes No		

8. Do you use more than two pillows to sleep? ..... 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.

Furthermore, I consent to a course of dental treatment, to the taking of dental x-rays for diagnostic purposes only, and to the use of local anesthesia/analgesic and to taking of oral photographs to be used without revealing my identity for the furthering of dental knowledge. Furthermore, I assume financial responsibility for the treatment rendered.

_____ Date
Patient (or guardian) Signature

_____ Date
Reviewed by

← (Please complete other side) →