

Medical History

Patient name: _____

1. Have you been under the care of a physician during the past two years? Yes No

If yes, for what? _____

Physician's name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medications or drugs during the past two years? Yes No

3. Are you taking any medications, pills, or drugs now? Yes No

If yes, please list name and dosage

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

4. Are you aware of having any allergic (or adverse) reaction to any medication or substance?

Yes No

If yes, please list/explain _____

5. Have you been in a hospital for treatment in the past 5 years? Yes No

If yes, please

explain _____

6. Indicate which of the following you have had, or have at the present. You must circle "Y" for yes or "N" for no on each item.

Heart (surgery,disease,attack)	Y	N	Ulcers	Y	N	A.I.D.S.	Y	N
Chest pain	Y	N	Diabetes	Y	N	HIV positive	Y	N
Congenital heart disease	Y	N	Thyroid problems	Y	N	Cold sores	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	Hemophilia	Y	N
High blood pressure	Y	N	Emphysema	Y	N	Sickle cell disease	Y	N
Mitral valve prolapse	Y	N	Tuberculosis	Y	N	Liver disease	Y	N
Artificial heart valve	Y	N	Asthma	Y	N	Jaundice	Y	N
Pacemaker	Y	N	Latex sensitivity/allergy	Y	N	Neurological disorders	Y	N
Arthritis/rheumatism	Y	N	Allergies or hives	Y	N	Epilepsy or seizures	Y	N
Cortisone medicine	Y	N	Sinus troubles	Y	N	Fainting or dizzy spells	Y	N
Stroke	Y	N	Radiation therapy	Y	N	Nervous/anxious	Y	N
Diet (special/restricted)	Y	N	Chemotherapy	Y	N	Panic attacks	Y	N
Artificial joints (hip, knee, etc.)	Y	N	Tumors	Y	N	Psychiatric/psychological care	Y	N
Kidney trouble	Y	N	Hepatitis	Y	N	Metal allergies/reactions	Y	N

7. Do you have or have you had any disease, condition, or problem not listed?

8. **Women:** Are you **pregnant?** Yes, ____ months No **Nursing?** Taking **birth control pills?** Yes No

(Doctor use only) Antibiotics rxn discussed _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the 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 changes in my health or medication.

Patient/guardian signature _____ Date _____

Dr. Nov's signature after review _____ Date _____