

MEDICAL HISTORY FORM

PATIENT NAME: _____

NAME OF DENTIST: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE:(_____)_____

NAME OF PHYSICIAN: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE:(_____)_____

Emergency Contact (Nearest relative not living with you)

NAME: _____

ADDRESS: _____

PHONE:(_____)_____

CITY: _____ ST: _____ ZIP: _____

Please circle YES or NO to the following: The answers are for the office records only and will be considered confidential.

YES NO Are you presently under a physician's care? If so, for what _____
YES NO Have you ever been advised to premedicate with antibiotics for dental appointments?
YES NO Has there been any change in your health in the past year? If yes, please explain: _____
YES NO Women – Are you pregnant?

Do you have or have had any of the following?

YES	NO	Heart Disease, Murmur, Angina, Attack	YES	NO	Rheumatic Fever
YES	NO	Mitral Valve Prolapse	YES	NO	Hepatitis (yellow jaundice)
YES	NO	Stroke	YES	NO	Hepatitis B
YES	NO	Do you wear a pacemaker?	YES	NO	Hepatitis C
YES	NO	Do you have cardiac valve prosthesis?	YES	NO	High or low blood pressure
YES	NO	Jaundice or liver diseases	YES	NO	Diabetes
YES	NO	HIV or AIDS	YES	NO	Tuberculosis
YES	NO	Venereal Disease	YES	NO	Do you have any artificial prosthesis?
YES	NO	Chest pains or shortness of breath	YES	NO	Cancer
YES	NO	Arthritis	YES	NO	Medical radiation treatments
YES	NO	Epilepsy or seizures	YES	NO	Stomach ulcers
YES	NO	Sinus problems, asthma or hay fever	YES	NO	Abnormal bleeding or blood disorders
YES	NO	Any other medical conditions: If so, what _____			

Are you allergic to or react adversely to:

YES	NO	Penicillin	YES	NO	Ibuprofen
YES	NO	Aspirin	YES	NO	Antibiotics
YES	NO	Latex	YES	NO	Other _____

Are you presently taking any of the following medications?

YES	NO	Antibiotics	YES	NO	Birth control
YES	NO	Medication for high blood pressure	YES	NO	Heart medication
YES	NO	Medication for Diabetes	YES	NO	Other _____

YES NO I hereby give my permission to have my or my child's diagnostic records (radiographs, photos, study models) used for teaching, diagnostic and marketing purposes.

DATE: _____ SIGNATURE: _____

DATE: _____ DR. SIGNATURE: _____