Medical History

Patient's Name ______________________________ Date __________

Medical Doctor's Name ______________________ Phone __________

Are you under a doctor's care now? **YES** **NO** Why? ____________________

Do we have your permission to contact her/him regarding your care? **YES** **NO**

Have you been hospitalized during the past two years? **YES** **NO** For what? ________

____

Are you taking medications, pills or drugs? **YES** **NO** List drug(s) & reason for taking;

____

____

Do you require antibiotic pre-medication for your dental work? **YES** **NO**

What for? ____

Are you allergic to any medications or substance? **YES** **NO** List: ______________

____

Women: Are you pregnant? **YES** **NO** How far along? ____________________

Please CIRCLE if you have ever had any of the following:

Allergies	Diabetes	Hepatitis A	Rheumatism
Anemia	Dizziness	Hepatitis B	Scarlet Fever
Angina	Drug Addiction	Hepatitis C	Seizures
Artificial Heart Valve	Emphysema	Herpes	Shortness of Breath
Artificial Hip/Joints	Epilepsy	High Blood Pressure	Sickle Cell Anemia
Arthritis/Gout	Excessive Thirst	HIV+/AIDS	Sinus Trouble
Asthma	Fainting	Hypoglycemia	Stroke
Blood Disease	Fever Blisters	Kidney Disease	Swelling of Limbs
Blood Transfusion	Frequent Cough	Liver Disease	Tattoos/Body Piercing
Bruise Easily	Glaucoma	Low Blood Pressure	Thyroid Disease
Cancer	Hay Fever	Lung Disease	TMD/TMJ
Chemotherapy/Radiation	Heart Murmur	Nervousness	Tuberculosis
Chest Pain	Heart Pacemaker	Pain in Jaw Joints	Ulcers
Cold Sores	Heart Surgery	Parathyroid Disease	Venereal Disease
Congenital Heart Lesion	Heart Trouble	Psychiatric Care	X-ray or Cobalt Tmt.
Cortisone Medicine	Hemophilia	Rheumatic Fever	Yellow Jaundice

Have you ever had any other serious illness not circle above? **YES** **NO**

Please describe in detail; ____

Are you being/have you ever been treated for cancer of any kind? **YES** **NO**

Please explain; ____

Do you wish to talk to the doctor privately about any problems/concerns? **YES** **NO**

______________________________________ ________________

Patient Signature (Parent or Guardian) Date

Reviewed by: ______________________________ __________ __________

(Title) Date BP