

**PATIENT**

▶ **Your Name (Patient's Name):** \_\_\_\_\_ **Date of last visit:** \_\_\_\_\_

**MEDICAL HISTORY**

▶ **Physician's Name:** \_\_\_\_\_ **Date of last visit:** \_\_\_\_\_

▶ **Have you ever been diagnosed with or experienced the following conditions?**

|                                   |   |                       |   |                                   |   |
|-----------------------------------|---|-----------------------|---|-----------------------------------|---|
| AIDS/HIV                          | <input type="checkbox"/> Y <input type="checkbox"/> N | Glaucoma              | <input type="checkbox"/> Y <input type="checkbox"/> N | Shortness of breath               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Anemia                            | <input type="checkbox"/> Y <input type="checkbox"/> N | Headaches             | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus trouble                     | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis, Rheumatism             | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart murmur          | <input type="checkbox"/> Y <input type="checkbox"/> N | Skin rash                         | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial heart valves           | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart problems        | <input type="checkbox"/> Y <input type="checkbox"/> N | Special diet                      | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial joints                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis Type _____  | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke                            | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Asthma                            | <input type="checkbox"/> Y <input type="checkbox"/> N | Herpes                | <input type="checkbox"/> Y <input type="checkbox"/> N | Swollen feet or ankles            | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Back problems                     | <input type="checkbox"/> Y <input type="checkbox"/> N | High blood pressure   | <input type="checkbox"/> Y <input type="checkbox"/> N | Swollen neck glands               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bleeds abnormally                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Jaundice              | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid problems                  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood disease                     | <input type="checkbox"/> Y <input type="checkbox"/> N | Jaw pain              | <input type="checkbox"/> Y <input type="checkbox"/> N | Tonsillitis                       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bone Density Medication           | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney disease        | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis                      | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer                            | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver disease         | <input type="checkbox"/> Y <input type="checkbox"/> N | Tumor or growth on head or neck   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chemotherapy                      | <input type="checkbox"/> Y <input type="checkbox"/> N | Low blood pressure    | <input type="checkbox"/> Y <input type="checkbox"/> N | Ulcer                             | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N | Venereal disease                  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Circulatory problems              | <input type="checkbox"/> Y <input type="checkbox"/> N | Nervous problems      | <input type="checkbox"/> Y <input type="checkbox"/> N | Weight loss, unexplained          | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Congenital heart lesions          | <input type="checkbox"/> Y <input type="checkbox"/> N | Pacemaker             | <input type="checkbox"/> Y <input type="checkbox"/> N | Major surgery? _____              | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cortisone treatments              | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric care      | <input type="checkbox"/> Y <input type="checkbox"/> N | Hospitalized for? _____           | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes                          | <input type="checkbox"/> Y <input type="checkbox"/> N | Radiation treatment   | <input type="checkbox"/> Y <input type="checkbox"/> N | Do you wear contact lenses?       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Emphysema                         | <input type="checkbox"/> Y <input type="checkbox"/> N | Respiratory disease   | <input type="checkbox"/> Y <input type="checkbox"/> N | Take any non-prescribed drugs?    | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Epilepsy                          | <input type="checkbox"/> Y <input type="checkbox"/> N | Scarlet fever         | <input type="checkbox"/> Y <input type="checkbox"/> N | If yes, what and how often? _____ |   |

▶ **Do you have any other dental or medical condition(s) that could affect your dental treatment?** If so, please describe below:

WOMEN ONLY Pregnant? Due date \_\_\_\_\_  Y  N Taking birth control pills?  Y  N Are you nursing?  Y  N

▶ **Have you ever taken any of the group of drugs collectively referred to as "fen-phen"?** These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). \_\_\_\_\_ Yes \_\_\_\_\_ No

▶ **List all medications you are currently taking and the correlating diagnosis:**

Med: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ For: \_\_\_\_\_

Med: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ For: \_\_\_\_\_

Med: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ For: \_\_\_\_\_

Med: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ For: \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

▶ **Indicate all of your allergies below:**

Aspirin  Iodine  Penicillin

Barbiturates  Latex  Sulfa

Codeine  Local  Other

anesthetic \_\_\_\_\_

**ACKNOWLEDGEMENT**

▶ **Check ONE and acknowledge with your signature below:**

I have had no change in my dental or medical history since my last visit.

I attest that the dental and medical information above is current, complete, true, and accurate. I accept full responsibility for any information not updated or shared with the doctor.

**Patient (or Guardian) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name (if signing for minor):** \_\_\_\_\_