

MEDICAL HISTORY

NAME: _____ **Date:** _____

Date of Birth _____ **Occupation:** _____

1. Have you been under the care of a medical doctor during the past three years? Yes No
If yes, for what? _____
Physician's Name: _____ Phone Number: _____
Address _____ City _____ State _____ Zip _____
2. Have you taken any medications or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pill now, including regular dosages of aspirin? Yes No
If yes, please list name and dosage _____

4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
If yes, did you take any of the following: Fen-Phen (Fenfluramine-Phentermine) Yes No
Pondimin (Fenfluramine) Yes No
Redux (Dexfenfluramine) Yes No
If yes to any of the above, did you have a medical exam for heart tissue? Yes No
5. Are you or have you taken any of the following medications?
_____ Residronate (Actonel) _____ Tiludronate (Skelid) _____ Pamidronate (Aredia)
_____ Etidronate (Didronel) _____ Alendronate (Fosamax) _____ Zolendronate (Zometa)
How long were you taking medication? _____ How taken? _____ Oral _____ IV
6. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Y N
If yes, please list: _____
7. Have you been a patient in the hospital during the past five years? Yes No
If "Yes", for what: _____
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 to Pre-Medicate prior to having any dental cleanings or work done? Yes No
11. WOMEN: Are you: Pregnant? Yes, _____ Months No
Nursing? Yes No
Taking Birth Control pills? Yes No

NAME: _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no"

- | | | | | | | |
|------------------------------------|-----|----|--------------------------------|--------------|-----|----|
| Chest Pain | Yes | No | Hay Fever | Yes | No | |
| Congenital Heart Disease | Yes | No | Asthma | Yes | No | |
| Heart (surgery,disease,attack) | Yes | No | When: _____ | Tuberculosis | Yes | No |
| Heart Murmur | Yes | No | Chronic Cough | Yes | No | |
| Artificial Heart Valve | Yes | No | Contact Lenses | Yes | No | |
| Heart Pacemaker | Yes | No | Drug/Alcohol Addiction: | Yes | No | |
| Mitral Valve Prolapse | Yes | No | High Blood Pressure | Yes | No | |
| Allergies or Hives | Yes | No | A.I.D.S. | Yes | No | |
| Latex Sensitivity | Yes | No | H.I.V. Positive | Yes | No | |
| Rheumatic Fever | Yes | No | Cold Sores/Fever Blisters | Yes | No | |
| Arthritis/Rheumatism | Yes | No | Blood Transfusion | Yes | No | |
| Cortisone Medicine | Yes | No | Hemophilia | Yes | No | |
| Swollen Ankles | Yes | No | Sickle Cell Disease | Yes | No | |
| Stroke | Yes | No | Bruise Easily | Yes | No | |
| Diet (Special/Restricted) | Yes | No | Liver Disease | Yes | No | |
| Artificial Joints (hip, Knee, Etc) | Yes | No | Yellow Jaundice | Yes | No | |
| Kidney Trouble | Yes | No | Neurological Disorders | Yes | No | |
| Ulcers | Yes | No | Epilepsy or Seizures | Yes | No | |
| Diabetes | Yes | No | Fainting or Dizzy Spells | Yes | No | |
| Thyroid Problems | Yes | No | Nervous/ Anxious | Yes | No | |
| Glaucoma | Yes | No | Psychiatric/Psychological Care | Yes | No | |
| Emphysema | Yes | No | Tumors | Yes | No | |
| Sinus Trouble | Yes | No | Venereal Disease/HPV/Herpes | Yes | No | |
| Hepatitis "A" | Yes | No | Cancer | Yes | No | |
| Hepatitis "B" | Yes | No | Type: _____ | Radiation | Yes | No |
| Headaches | Yes | No | When: _____ | Chemotherapy | Yes | No |
| Back Problems | Yes | No | When: _____ | | | |

Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please List: _____

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 change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

MEDICAL HISTORY UPDATE
PATIENT SIGNATURE

DATE

COMMENTS
