

# MEDICAL HISTORY

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

WHOM MAY WE NOTIFY IN CASE OF EMERGENCY? \_\_\_\_\_

RELATIONSHIP TO YOU \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

CLINIC OR FACILITY NAME \_\_\_\_\_

### **CIRCLE THE APPROPRIATE ANSWERS**

- YES NO DO YOU NEED TO TAKE ANTIBIOTIC PRE-MED BEFORE DENTAL APPOINTMENTS?
- YES NO ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?  
IF YES, DESCRIBE YOUR TREATMENT \_\_\_\_\_
- YES NO HAVE YOU HAD ANY MEDICAL TREATMENT OR PHYSICIAN VISIT OF ANY KIND IN THE LAST YEAR?  
IF YES, DESCRIBE \_\_\_\_\_
- YES NO HAVE YOU EVER HAD ANY SURGICAL OPERATION OF ANY KIND?  
IF YES, DESCRIBE \_\_\_\_\_
- YES NO HAVE YOU EVER BEEN HOSPITALIZED? IF YES, WHAT FOR AND WHEN?  
\_\_\_\_\_
- YES NO HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? IF YES, WHEN? \_\_\_\_\_
- YES NO WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM? \_\_\_\_\_
- YES NO ARE YOU CURRENTLY TAKING ANY PRESCRIPTION DRUG?  
IF YES, NAME & NEED \_\_\_\_\_
- YES NO ARE YOU CURRENTLY TAKING ANY NON-PRESCRIPTION DRUG OF ANY KIND?  
(EXAMPLE: ASPIRIN, COUGH SYRUP, NASAL SPRAY, RECREATIONAL DRUG USE, HIGH SUGAR INTAKE, HIGH CAFFEINE INTAKE) IF YES, NAME & NEED \_\_\_\_\_
- YES NO HAVE YOU HAD PROBLEMS WITH PENICILLIN, ANTIBIOTICS, AND/OR ANESTHETICS?
- YES NO HAVE YOU HAD AN ALLERGIC REACTION TO ANY MEDICATIONS OR SUBSTANCES?  
IF YES, DESCRIBE \_\_\_\_\_
- YES NO DO YOU SMOKE OR CHEW TOBACCO? (UNDERLINE WHICH ONE)
- YES NO DO YOU CONSUME ALCOHOLIC BEVERAGES?
- YES NO HAVE YOU HAD ANY ALLERGIC REACTION TO METALS OR JEWELRY? WHAT KIND? \_\_\_\_\_
- YES NO WOMEN - ARE YOU PREGNANT OR SUSPECT YOU MIGHT BE?

### **PLEASE PUT A CHECK BY THE ONES YOU HAVE, HAVE HAD, OR BEEN TREATED FOR.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ARTHRITIS                              | <input type="checkbox"/> CHEST PAIN                       | <input type="checkbox"/> EAR INFECTIONS                      |
| <input type="checkbox"/> RHEUMATIC FEVER                        | <input type="checkbox"/> SHORTNESS OF BREATH              | <input type="checkbox"/> BRUISE EASILY                       |
| <input type="checkbox"/> HEART PROBLEMS                         | <input type="checkbox"/> SWELLING OF FEET/ANKLES/HANDS    | <input type="checkbox"/> PSYCHIATRIC CARE                    |
| <input type="checkbox"/> CONGENITAL HEART LESION                | (CIRCLE APPROPRIATE)                                      | <input type="checkbox"/> DRUG ADDICTION                      |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                    | <input type="checkbox"/> STROKE                           | <input type="checkbox"/> ALZHEIMER'S DISEASE                 |
| <input type="checkbox"/> LOW BLOOD PRESSURE                     | <input type="checkbox"/> EXCESSIVE THIRST                 | <input type="checkbox"/> ARTIFICIAL HEART VALVE              |
| <input type="checkbox"/> CHRONIC ALLERGY,<br>MILD REACTIONS TO: | <input type="checkbox"/> HAY FEVER                        | <input type="checkbox"/> LATEX ALLERGY                       |
| <input type="checkbox"/> ANEMIA, SICKLE CELL DISEASE            | <input type="checkbox"/> HEMOPHILIA,                      | <input type="checkbox"/> HYPOGLYCEMIA                        |
| <input type="checkbox"/> EPILEPSY, SEIZURES                     | <input type="checkbox"/> BLEEDING OR BLOOD DISORDER       | <input type="checkbox"/> COLD SORES, HERPES,<br>CANKER SORES |
| <input type="checkbox"/> CHRONIC SINUS                          | <input type="checkbox"/> ASTHMA                           | <input type="checkbox"/> FAINTING SPELLS                     |
| <input type="checkbox"/> DIABETES                               | <input type="checkbox"/> CORTISONE MEDICATION WHEN? _____ | <input type="checkbox"/> TUBERCULOSIS                        |
| <input type="checkbox"/> FREQUENT COUGH                         | <input type="checkbox"/> EMPHYSEMA                        | <input type="checkbox"/> LUNG DISEASE                        |
| <input type="checkbox"/> NERVOUSNESS                            | <input type="checkbox"/> ULCERS                           | <input type="checkbox"/> LIVER DISEASE                       |
| <input type="checkbox"/> HIP OR JOINT REPLACEMENT               | <input type="checkbox"/> KIDNEY DISORDER                  | <input type="checkbox"/> HEPATITIS A (INFECTION)             |
| <input type="checkbox"/> HYDROCEPHALUS                          | <input type="checkbox"/> ENZYME DEFICIENCY (i.e.) G6PD    | <input type="checkbox"/> RHEUMATISM                          |
|   | <input type="checkbox"/> HEPATITIS B (SERUM)              |  |

