

MEDICAL HISTORY

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

Check (✓) if you have or have had problems with any of the following:

| | | | | | |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocarditis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma or Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Claustrophobia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| COPD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles or mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | Nasal Obstruction | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (✓) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

| | Presently Taking | Taken in the Past | History of Reaction | | Presently Taking | Taken in the Past | History of Reaction | | Presently Taking | Taken in the Past | History of Reaction |
|--------------------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Anesthetics, Locally Injected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone or Other Steroids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insulin or Diabetes Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anesthetics, General | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coumadin, Heparin, Warfarin or other blood thinners | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives or Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antacids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dilantin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Pills (Barbiturates) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anti-anxiety Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diuretics (water pills) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Medication such as Synthroid, Levoxyol or Levothyroxine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anti-depressants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tylenol (Acetomeniphen) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antihistamines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Medications such as Digoxin, Nitroglycerin or Digitalis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adverse reaction to any other medication or drug | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Daily Aspirin Regimen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen (Motrin) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Please specify _____ | | | |
| Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | _____ | | | |
| Blood Pressure Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | _____ | | | |
| Codeine, Demerol or Other Analgesics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | _____ | | | |

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

| Medication | Condition | Prescribing Doctor |
|------------|-----------|--------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Pharmacy Name _____ Phone () _____

Women: Are you pregnant? Yes No Nursing? Yes No Have you had any serious illnesses or surgeries? Yes No If yes, describe _____

Check (✓) your current use of:

Tobacco Yes No
Packs per day _____
Alcohol, Beer, Wine Yes No
Drinks per day _____
Street Drugs Yes No
Times per day _____
Caffeine Yes No
Cups per day _____
High Stress Yes No
Reason _____

Do you have any other health needs you should bring to our attention? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient