MEDICAL HISTORY

Patient Name	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? _____
   Physician's Name: _____ Phone: _____
   Address: _____ City: _____
2. Have you taken any medication or recreational drugs during the past two years? Yes No
   Are you currently taking any medications or recreational drugs? Yes No
   If yes, please list name and dosage_____
3. Are you allergic to, or have you reacted adversely to any medication or substance? Yes No
   If yes, please list: _____
4. Have you been hospitalized in the past five years? Yes No
5. Indicate any of the following you have had, or currently have: (please check any that apply)

- ☐ Immunocompromised
- ☐ Heart (Surgery, Disease, Attack)
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Rheumatic Fever
- ☐ Arthritis/ Rheumatism
- ☐ Cortisone Medicine
- ☐ Swollen Ankles
- ☐ Stroke
- ☐ Diet (Special/Restricted)
- ☐ Artificial Joints (hip, knee, etc.)
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Contact lenses
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Latex Sensitivity
- ☐ Allergies or Hives
- ☐ Sinus Trouble
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Tumors
- ☐ Hepatitis A (infectious) B (serum)
- ☐ Sexually Transmitted Diseases
- ☐ A.I.D.S. or H.I.V. Positive
- ☐ Cold Sores/ Fever Blisters
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Bruise Easily
- ☐ Liver Disease
- ☐ Jaundice (yellowing)
- ☐ Neurological Disorders
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous/Anxious
- ☐ Psychiatric/Psychological Care

WOMEN:

- ☐ Pregnant, Due date_____
- ☐ Nursing
- ☐ Taking contraceptives

6. Do you smoke or use chewing tobacco? Yes No
7. Do you use more than two pillows to sleep? Yes No
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. 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 any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____