PATIENT NAME: _____ **MEDICAL HISTORY**

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: _____ State: _____
2. Have you taken any prescription, herbal, or over the counter medications in the past two years? YES NO
   If yes, please list name and dosage:
   _____
   _____
   _____
3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES NO
   If yes, please list: _____
4. Have you been a patient in the hospital during the past five years? YES NO

Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item.

Heart (Surgery, Disease, Attack)	YES	NO	Ulcers	YES	NO	Hepatitis A or B	YES	NO
Chest Pain	YES	NO	Diabetes	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Thyroid Problems	YES	NO	AIDS	YES	NO
Heart Murmur	YES	NO	Glaucoma	YES	NO	HIV Positive	YES	NO
High Blood Pressure	YES	NO	Contact Lenses	YES	NO	Cold Sores/Fever	YES	NO
Mitral Valve Prolapsed	YES	NO	Emphysema	YES	NO	Blisters	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Blood Transfusion	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Hemophilia	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Sickle Cell Disease	YES	NO
Arthritis/Rheumatism	YES	NO	Hay Fever	YES	NO	Bruise Easily	YES	NO
Cortisone Medicine	YES	NO	Latex Sensitivity	YES	NO	Liver Disease	YES	NO
Swollen Ankles	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Diet (Special/Restricted)	YES	NO	Sinus Trouble	YES	NO	Neurological Disorders	YES	NO
Artificial Joints (hip, knees)	YES	NO	Radiation Therapy	YES	NO	Epilepsy or Seizures	YES	NO
Kidney Trouble	YES	NO	Chemotherapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Stroke	YES	NO	Tumors	YES	NO	Nervous/Anxious	YES	NO
						Psychiatric/ Psychological Care	YES	NO

5. Do you take, or have you taken diet drug Phen-Fen or Redux?* YES NO
   *If yes to the above, did you have a medical exam for heart issues? YES NO
6. Are you taking any medication for the treatment of osteoporosis or bone disease? 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: _____
10. Women: Pregnant? Yes___ # months___ No___ Nursing? Yes No Taking birth control pills? Yes No

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 _____

Dentist Signature _____ Date _____