Medical History

Patient's Name: _____ Gender: Male ☐ Female ☐

Date of Birth: _____ Age: _____ Weight _____ Height: _____

1. Are you in good health? ..... Yes ☐ No ☐
2. Are you now or have you been under the care of a physician in the last year? ..... Yes ☐ No ☐
   If so, for what? _____
3. Are you taking any drugs or medications at the present time? ..... Yes ☐ No ☐
   If so, what? _____

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4. What Premed(s) have you taken? _____
5. Are you allergic to any drugs or medications? ..... Yes ☐ No ☐
   If so, what? _____
6. Do you smoke cigarettes ..... Yes ☐ No ☐
7. Do you now have a cold or sore throat? ..... Yes ☐ No ☐
8. Have you had any of the following? Please mark yes or no.

	Y	N		Y	N		Y	N		Y	N
Heart Failure	☐	☐	Hemophilia	☐	☐	Thyroid Disease	☐	☐	Rheumatism	☐	☐
Heart Disease or Attack	☐	☐	Sickle Cell Disease	☐	☐	Allergies or hives	☐	☐	Artificial Joint	☐	☐
Angina (chest Pain)	☐	☐	Bruise Easily	☐	☐	Hay Fever	☐	☐	Immune System Compromise	☐	☐
Mitral Valve Prolapse	☐	☐	Emphysema	☐	☐	AIDS/HIV	☐	☐	Radiation, X-ray or Cobalt Treatment	☐	☐
High Blood Pressure	☐	☐	Bronchitis	☐	☐	AIDS Related Complex	☐	☐	Chemotherapy (Cancer, Leukemia)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Psychiatric Treatment	☐	☐
Heart Murmur	☐	☐	Cough	☐	☐	Hepatitis	☐	☐	Nervousness	☐	☐
Rheumatic Fever	☐	☐	Tuberculosis (TB)	☐	☐	Yellow Jaundice	☐	☐	Drug/Alcohol Addiction	☐	☐
Congenital Heart Lesions	☐	☐	Shortness of Breath	☐	☐	Kidney Trouble	☐	☐	Ulcers	☐	☐
Artificial Heart Valve	☐	☐	Stroke	☐	☐	Arthritis	☐	☐	Sinus Trouble	☐	☐
Heart Pacemaker	☐	☐	Epilepsy or Seizures	☐	☐	Cortisone Medicine	☐	☐		☐	☐
Heart Surgery	☐	☐	Fainting or Dizzy Spells	☐	☐	Infection	☐	☐		☐	☐
Excessive Bleeding	☐	☐	Diabetes	☐	☐	Pain in Jaw Joints	☐	☐		☐	☐
Anemia	☐	☐	Swelling of the Ankles	☐	☐	Cerebral Palsy	☐	☐		☐	☐
Blood Transfusion	☐	☐	Glaucoma	☐	☐	Contact Lenses	☐	☐		☐	☐

9. When you walk up stairs or take a walk, do you have to stop because of pain in your chest, or shortness of breath? ..... Yes ☐ No ☐
10. Have you experienced an unfavorable reaction to previous dental treatment? ..... Yes ☐ No ☐
11. Do you use more than 2 pillows to sleep? ..... Yes ☐ No ☐
12. Have you lost or gained more than 10 pounds in the past year? ..... Yes ☐ No ☐
13. Have you had any previous operation or surgery? ..... Yes ☐ No ☐
14. Are you on a special diet? ..... Yes ☐ No ☐
15. Has your medical doctor ever said you have a cancer or tumor? ..... Yes ☐ No ☐
16. Do you have any disease, condition, or problem not listed? ..... Yes ☐ No ☐
17. Reason for visit and/or current problem? _____

**************FOR ADULT FEMALES ONLY**************

18. Are you pregnant?
    If so, how many months? _____ Are you planning a pregnancy?
19. Are you nursing?
20. Are you taking birth control pills?
    If not, do you plan to take birth control pills in the future?

To the Best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_____ _____

Date Signature of Patient, Parent or Guardian