



Medical History

Medical Alert _____

1. Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Current Medications _____

3. Any Allergy to drugs or any Anesthesia? _____

4. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

- | | | |
|---|---|--|
| Heart (surgery, disease, attack)... <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No | A.I.D.S. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No | H.I.V. Positive..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/ Fever Blisters..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Pacemaker..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/ Rheumatism..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies or Hives..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (special/ restricted)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/ Anxious..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints (hip, knee, etc.)... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/ Psychological Care.. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A(infectious) B(serum).. <input type="checkbox"/> Yes <input type="checkbox"/> No | |

5. List any other diseases or conditions not listed above.

6. Are you: Pregnant? Nursing? Taking birth control pills?

7. Have you ever taken Phen Phen? Yes No

I understand the above information 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 _____

HISTORY REVIEW

DOCTOR SIGNATURE _____ DATE _____