

MEDICAL HISTORY

Name	Medical Alert
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*Welcome! So that we may provide you with the best possible care, please complete this medical history form.
All information is completely confidential.*

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 no. _____
 Address _____ City _____ State _____ Zip code _____
2. Have taken any medication during the past two years? Yes No
3. Are you taking any medication now? Including regular dosages of aspirin? Yes No
 If yes, please list name and dosage _____
4. Have you ever taking medication for weigh loss? Yes No
5. Are you aware of having allergic reaction to any medication or substance? Yes No
 If yes, please list _____
6. Have you been a patient in the hospital during the last five years? Yes No
7. Indicate which of the following you have had. Circle "Yes" or "No"

Heart(surgery, disease....)	Yes	No	Ulcers	Yes	No	Hepatitis	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problem	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medication	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergy/Hives	Yes	No	Neurological Disorder	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting/Dizzy Spell	Yes	No
Artificial Joints	Yes	No	Chemo Therapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychological Care	Yes	No

8. Do you have more than two pillows to sleep?
9. Have you lost or gain more than ten pounds in the past year?
10. Do you have or have you had any diseases, conditions, or problems not listed?
 If yes, please list _____
11. Women: Are you Pregnant? Yes, Month No
 Nursing? Yes, Month 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 changes in my health or medications.

Patient/Guardian's signature _____ Date _____