

Patient Name: _____

MEDICAL HEALTH HISTORY

Name of physician: _____ Physician's Phone # _____ - _____ - _____.

Name of Previous Dentist: _____ Reason for leaving _____

Date of last visit to Physician ____/____/____

Do you have or have had, any of the following? Please answer **Yes or No** or explain.

	Yes	No		Yes	No
Heart Problems					
· Chest Pain			Fainting Spells, Seizures, or Epilepsy		
· Shortness of breath			Diabetes		
· Blood pressure problems			Tuberculosis or other respiratory disease		
· Heart murmur			Cancer/Tumor		
· Heart Valve problem			Hepatitis, Jaundice, or Liver Trouble		
· Taking Heart medication			Herpes		
· Rheumatic fever			HIV-Positive/ AIDS		
· Pacemaker			Glaucoma		
· Artificial Heart Valve			Have you been hospitalized during the past 5 years?		
• Other _____			Do you have any disease, problem or condition not listed?		
Blood Problems					
· Easy Bruising			Do you have any psychiatric problems?		
· Frequent nose bleeding			During the past 12 mo. Have you taken any of the following?		
· Abnormal bleeding			· Antibiotics or sulfa drugs		
· Blood disease(anemia)			· Anticoagulants		
• Other _____			· High blood pressure medicine		
Allergy Problems					
· Hay fever			· Tranquilizer		
· Sinus problem			· Insulin, Orinase, or similar drug		
· Skin Rashes			· Aspirin (daily)		
· Taking allergy medication			· Digitals or drugs for heart problems		
· Asthma			· Nitroglycerine		
• Other _____			· Cortisone(steroids)		
			· List Meds you take every day		
Intestinal Problems					
· Ulcers			Woman		
· Weight gain or loss			Are you taking contraceptives?		
· Special diet			Other Hormones?		
· Constipation			Are you pregnant?		
· Other _____			If so, expected delivery date ____/____/____		
Bone or Joint Problems					
· Arthritis					
· Back or Neck pain					
· Joint replacement			Are you allergic to any of the following:		
· Pins or metal rods			· Local anesthetics (Novocaine)		
• Other _____			· Penicillin or other antibiotics		
REMARK: DOCTOR USE					
			· Sulfa Drugs		
			· Barbiturates, sedatives, or sleeping pills		
			· Aspirin		
Blood Pressure			· Codeine		
Pulse			· Other _____		
			· Other _____		
			· Other _____		

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 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 ____/____/____.

Doctor Signature _____