

Patient Name _____ SS # _____

MEDICAL HISTORY

- | | CIRCLE | List Medication/Dose |
|--|--------|----------------------|
| 1. Are you having pain or discomfort at this time?..... | YES NO | _____ |
| 2. Have you been hospitalized in the past two years?..... | YES NO | _____ |
| 3. Have you been under the care of a medical doctor during the past two years?..... | YES NO | _____ |
| 4. Have you taken medicine or drugs during the past two years?..... | YES NO | _____ |
| 5. Do you have any medical allergy (i.e. penicillin, aspirin, codeine, <i>Latex</i>)? If so, please describe your reaction..... | YES NO | _____ |
| 6. Have you ever had any excessive bleeding requiring special treatment..... | YES NO | _____ |
| 7. Do you ever experience shortness of breath or pain in your chest while walking up stairs?.... | YES NO | _____ |
| 8. Do you ever wake up from sleep short of breath?..... | YES NO | _____ |
| 9. Do you use more than 2 pillows to sleep?..... | YES NO | _____ |
| 10. Do your ankles swell during the day?..... | YES NO | _____ |
| 11. Have you lost or gained more than 10 pounds in the past year?..... | YES NO | _____ |
| 12. Are you on a special diet?..... | YES NO | _____ |
| 13. Have you ever been diagnosed with cancer?..... | YES NO | _____ |
| 14. Do you smoke? If so, how many packs a week?..... | YES NO | _____ |
| 15. Women: Are you pregnant now?..... | YES NO | _____ |
| Do you anticipate becoming pregnant?..... | YES NO | _____ |

16. Circle any of the following which you have had or have at present:

- | | | |
|---------------------------|--------------------------|--|
| Heart Failure | Emphysema | AIDS |
| Heart Disease or Attack | Chronic Cough | Hepatitis (A, B, C, D) |
| Angina Pectoris | Tuberculosis (TB) | Hepatitis (serum) |
| High / Low Blood Pressure | Asthma | Liver Disease |
| Heart Murmur | Hay Fever | Yellow Jaundice |
| Rheumatic Fever | Sinus Trouble | Blood Transfusion |
| Congenital Heart Lesions | Allergies / Hives | Drug Addiction |
| Scarlet Fever | Diabetes | Hemophilia |
| Artificial Heart Valve | Thyroid Disease | Venereal Disease (Syphilis, Gonorrhea) |
| Heart Pacemaker | X-Ray / Cobalt Treatment | Cold Sores |
| Heart Surgery | Chemotherapy | Genital Herpes |
| Artificial Joint | Cancer | Epilepsy or Seizures |
| Stroke | Arthritis | Fainting or Dizzy Spells |
| Headaches | Rheumatism | Nervousness |
| Kidney Trouble | Cortisone (steroid) Meds | Psychiatric Treatment |
| Dialysis | Glaucoma | Sickle Cell Disease |
| Ulcers | Bruise Easily | Anemia |
| Fen Phen Treatment | Bulimia | Anorexia |

17. Do you have any disease, condition, or problem not listed?..... YES NO
 If yes, describe condition: _____

Physician's Name: _____ Address: _____ Phone: _____

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

 Date Doctor Signature Patient or Guardian Signature

Medical History Update

Date	Update	Initials	Date	Update	Initials
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____