MEDICAL HISTORY

Physician's name ______________________________ Telephone__________ Last Medical exam date_______________

Are you currently being treated by physician?____

Are you allergic to any of the following? (please circle yes or no)

Penicillin	yes	no	aspirin	yes	no	dental anesthetics	yes	no
Sulfa drugs	yes	no	codeine	yes	no	other	yes	no
Latex	yes	no	metals	yes	no			

Women: Are you: ☐ pregnant? ☐ nursing? ☐ taking oral contraceptives?

Do you have or have had any of the following?

☐ AIDS/ HIV Positive
☐ Anemia
☐ Angina
☐ Asthma
☐ Breathing Problems
☐ Cancer
☐ Chemotherapy
☐ Cold sores, fever blisters
☐ Diabetes
☐ Drug Addiction
☐ Epilepsy/Seizures
☐ Fainting Spells
☐ Frequent cough
☐ Genital herpes
☐ Heart Condition *
☐ Heart Pace Maker *
☐ Heart valve, artificial *
☐ Hemophilia
☐ Hepatitis A, B
☐ Hepatitis C

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Kidney disease
☐ Liver disease
☐ Lung disease
☐ Mitral Valve Prolapse *
☐ Pain in the Jaw Joints
☐ Radiation Therapy
☐ Rheumatic Fever *
☐ Shingles
☐ Stroke
☐ Tuberculosis
☐ Tumors or growths
☐ Venereal Disease
☐ Other serious illness. Explain ______________________________
____
____

* Condition may require medication

What medications are you taking now? ____
____
____

To the best of my knowledge, the questions on this from have been accurately answered.
It is my responsibility to inform the dental office of any changes in medical status.

____
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

Periodic Patient Updates:
I have reviewed the information above and made necessary changes for an updated health history.

____
SIGNATURE DATE OF UPDATE