PATIENT MEDICAL HISTORY

(Please fill out both sides completely)

PATIENT'S NAME:_____ DATE OF BIRTH_____

MEDICAL PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM_____

IN CASE OF AN EMERGENCY, NOTIFY_____ RELATION W/ PATIENT_____ PHONE_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND THE MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. Are you in good health……		
2. Have there been any changes in your general health within the past year……		
3. Date of your last physical _____		
4. Physician's Name_____		
Address_____		
Phone No. _____		
5. Have you ever been hospitalized for any surgical operation or serious illness		
Please Explian_____		
6. Are you now under the care of a physician……		
7. Are you taking any medicine, including non-prescription medicine		
If YES, what medicine(s) are you taking		
_____		
_____		
_____		
_____		
8. Have you had any abnormal bleeding ……..		
9. Do you bruise easily ……		
10. Have you ever required a blood transfusion ……		
11. Have you had a recent weight loss ……		
12. Have you ever taken Fen-Phen or Redux……		
13. Do you use Tobacco……..……		
How much _____		
14. Do you or have you used controlled substances ……		
15. Are you wearing contact lenses……		
16, Do you have any disease, condition or problem not listed here that you think I should know about……		

Women Only:

Are you pregnant or think you may be pregnant……..…….		
Are you Nursing …….		
Are you taking birth control pills ……		

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
Local Anesthetics like Novocaine		
Penicillin or other antibiotics		
Sulfa Drugs		
Barbiturates, sedatives or sleepin pills		
Aspirin		
Iodine		
Any metals (e.g. Nickel, Mercury, etc.)		
Latex / Rubber		
Other (please specify) _____		

	YES	NO
Rheumatic heart disease or rheumatic fever ……		
Mitral valve prolapse ……		
Scarlet fever ……		
Hearth defect or hearth murmur ……		
Hearth trouble, hearth attack or angina……		
Chest pain ……		
Shortness of breath ……		
Pacemaker ……		
Hearth surgery ……		
High / Low blood pressure ……		
Congenital hearth problem ……		
Swelling of feet, ankle ……		
Hepatitis, jaundice or liver sisease ……		
Stroke ……		
Sinus trouble ……		
Lung or breathng problems ……		
Asthma or hay fever ……		
fainting or dizzy spells ……		
Diabetes ……		
Thyroid problems ……		
Allergies ……		
Join replacement or implant ……		
If yes, when _____		
Kidney trouble ……		
Tuberculosis ……		
Persistent cough ……		
Chemotherapy (Cancer, Leukemia) ……		
Sexual transmitted disease ……		
Epilepsy or seizures ……		
Anemia ……		
Nervousness ……		
Tumors ……		
Mental Health care ……		

Blood pressure ____-____/_____

	YES
Back Problems ……	
Chemical dependency ……	
Cortisone treatment ……	
Cold sores / fever blisters ……	
Hypoglycemia ……	

FOR OFFICE USE ON

MEDICAL UPDATE

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Medical Alert Sticker

Patient Signature _____ Date _____ Dentist Signature _____ Date _____