

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Have you ever had any of the following? (circle all that apply)

Heart Murmur	Epilepsy	Rheumatic Fever
High Blood Pressure	Headaches	Sinus Problems
Low Blood Pressure	Hepatitis/Jaundice/Liver	AIDS/HIV
Circulatory Problems	Disease	Thyroid Disease
Nervous Problems	Cancer	Stroke
Radiation Treatment	Allergies to Anesthetics	Ulcer
Artificial Heart Valves or Joints	Allergies to medicine or Drugs	Venereal Disease
Back Problems	Blood Disease	Chemical Dependency
Respiratory Disease	Arthritis	Hemophilia
Recent Weight Loss	Special Diet	Psychiatric Disorder
	Diabetes	Swollen Neck Glands
	Blood Transfusion	

Do you have any drug allergies or have you ever had an adverse reaction to any medication? \_\_\_\_\_ If so, when?

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_

Are you taking any medication at this time? \_\_\_\_\_ If so, what? \_\_\_\_\_

Are you under the care of a physician? YES NO

For what condition? \_\_\_\_\_

If patient is a child, what is his/her weight? \_\_\_\_\_

(Women) Do you suspect that you are pregnant? YES NO Are you Nursing? YES NO

Is there anything else we should know about your medical history? \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_

## MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? YES NO

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_