

# Medical History

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Last Exam: \_\_\_\_\_

Have you had any serious illnesses or operations?

Please Explain: \_\_\_\_\_

Are you currently under the care of a Physician? \_\_\_\_\_ If so,

Why? \_\_\_\_\_

## Have you ever had any of the following? Please circle those that apply:

... AIDS/HIV .. Hepatitis .. ... Anemia ... Asthma ... Joint Replacement ... Mitral Valve Prolapse  
... Diabetes ... Radiation Treatment ...  
... Heart Disease ... Tuberculosis ... Skin Rash ... Swelling of Legs or Ankles  
... Heart Murmur ... Transplant/Prostheses ... High Blood Pressure ... Pacemaker  
... Epilepsy ... Rheumatic Fever ... Migraines  
... Chemical Dependencies ... Latex Sensitive ... Allergic to Nickel?  
... Nervous Disorders

Do you take a bone-building drug such as Fosamax, Actonel, Zometa, Aredia or Pamidronate? If so, orally or IV? \_\_\_\_\_

Is there a possibility that you are currently pregnant? If so due date \_\_\_\_\_

Do you currently use tobacco?

If so, how long? \_\_\_\_\_ Do you want to quit? \_\_\_\_\_

List medications you are taking currently if any, including herbal and vitamin supplements:

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List any allergies you may have if any:

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I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand the importance of all the above information and that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

\_\_\_\_\_  
Signature of patient, parent or guardian