# MEDICAL HISTORY

| Your Name: | Date of Birth: | |
|---|---|---|
| Physician's Name: | | |
| Physician's Phone #: | | |
| 1. When was your last complete physical exam? | | |
| 2. Have you been a patient in a hospital during the past two years? | Yes | No |
| 3. Are you allergic to (i.e. itching, rash, swelling) or made sick by penicillin, tetracycline, codeine, aspirin, ibuprofen (Advil), acetaminophen (Tylenol), or any other medications? | Yes | No |
| 4. Have you ever had any excessive bleeding requiring special treatment? | Yes | No |
| 5. Do you bruise easily? | Yes | No |
| 6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? | Yes | No |
| 7. Do your ankles swell during the day? | Yes | No |
| 8. Do you use more than 2 pillows to sleep? | Yes | No |
| 9. Have you lost or gained more than 10 pounds in the past year? | Yes | No |
| 10. Do you ever wake up from sleep short of breath? | Yes | No |
| 11. Are you on a special diet? | Yes | No |
| 12. Has your medical doctor ever said you have a cancer or a tumor? | Yes | No |
| **Women:** Are you pregnant now? | Yes | No |
| Are you practicing birth control? | Yes | No |
| Do you anticipate becoming pregnant? | Yes | No |

**Please mark any of the following conditions if you presently have them or if you have had them in the past:**

- ○ Mitral Valve Prolapse
- ○ Heart Failure
- ○ Heart Disease or Attack
- ○ Angina Pectoris (chest pains)
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Heart Murmur
- ○ Rheumatic Fever
- ○ Congenital Heart Lesions
- ○ Scarlet Fever
- ○ Artificial Heart Valve
- ○ Heart Pacemaker
- ○ Heart Surgery
- ○ Artificial Joint
- ○ Anemia
- ○ Stroke
- ○ Kidney Trouble
- ○ Ulcers
- ○ Emphysema
- ○ Persistent Cough
- ○ Tuberculosis (TB)
- ○ Asthma
- ○ Hay Fever
- ○ Sinus Trouble
- ○ Allergies or Hives
- ○ Diabetes
- ○ Thyroid Disease
- ○ X-ray or Cobalt Treatment
- ○ Chemotherapy
- ○ Arthritis
- ○ Rheumatism
- ○ Cortisone or Steroid medication
- ○ Glaucoma
- ○ Hepatitis
- ○ Liver Disease
- ○ Yellow Jaundice
- ○ Blood Transfusion
- ○ Drug Addiction
- ○ Hemophilia
- ○ Sexually Transmitted Disease
- ○ Cold Sores
- ○ Herpes
- ○ Epilepsy or Seizures
- ○ Fainting or Dizzy Spells
- ○ Nervousness
- ○ Psychiatric Treatment
- ○ Sickle Cell Disease
- ○ Fen-Phen or Redux (diet medications)
- ○ Tobacco Use

*Please initial and continue on the next page.*

____________ Patient initials

____________ Dentist initials

## MEDICAL HISTORY

**In the space below, please list all medications including over the counter medications, vitamins, and herbals**.

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**Do you have any disease, condition, or problem not listed on this health history form**? YES NO

*To the best of my knowledge, all of my responses to the questions on this medical history form are true and correct. If I have any change in my health, or if my medications change, I will inform the doctor at my next appointment.*

____________________ Date

______________________________________ Signature of patient, parent, or guardian

____________________ Date

______________________________________ Signature of Dentist

Dentist’s Notes:

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