MEDICAL HISTORY

Patient Name: _____

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN? YES NO

PHYSICIAN'S NAME_____

PHYSICIAN'S ADDRESS_____

PHYSICIAN'S PHONE #_____

HAVE YOU TAKEN ANY BONE SUPPORT MEDICATION? YES NO

HAVE THERE BEEN ANY CHANGE IN YOUR HEALTH IN THE PAST YEAR YES NO

PLEASE LIST ALL MEDICATION OR DRUGS YOU ARE TAKING PRESENTLY:

MEDICATION	DOSAGE	FOR WHAT REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

RHEUMATIC FEVER	YES	NO	LIVER DISEASE(HEPATITIS/JAUNDICE)	YES	NO
HEART MURMUR	YES	NO	KIDNEY DISEASE	YES	NO
HYPOGLYCEMIA	YES	NO	TUBERCULOSIS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	HEMOPHILIA/BLEEDING	YES	NO
CONGENITAL HEART DEFECT	YES	NO	ANEMIA	YES	NO
HIGH/LOW BLOOD PRESSURE	YES	NO	CONVULSIONS/EPILEPSY	YES	NO
HEART ATTACK/CORONARY	YES	NO	VENEREAL DISEASE	YES	NO
ANGINA	YES	NO	HERPES VIRUS	YES	NO
HEART SURGERY	YES	NO	ARTIFICIAL JOINTS	YES	NO
STROKE	YES	NO	DATE:_____		
PSYCHIATRIC TREATMENT	YES	NO	PACEMAKER	YES	NO
PNEUMOTHORAX	YES	NO	ARTIFICIAL HEART VALVES	YES	NO
RESPIRATORY DISEASE	YES	NO	RADIATION TREATMENT	YES	NO
ASTHMA	YES	NO	EXCESSIVE BLEEDING		
DIABETES	YES	NO	FROM CUT OR EXTRACTION	YES	NO
ULCERS	YES	NO	NEUROLOGICAL DISORDERS	YES	NO
HIV POSITIVE	YES	NO	ARE YOU PREGNANT?	YES	NO
STATUS_____			HAVE YOU EVER TAKEN PHEN-FEN	YES	NO
GLAUCOMA	YES	NO			

ARE YOU ALERGIC TO OR HAVE YOU BEEN TOLD NOT TO TAKE ANY OF THE FOLLOWING? (PLEASE CHECK)

____PENICILLIN ____CODEINE ____ASPIRIN

____NOVOCAINE ____SULFA ____OTHER_____

ARE THERE ANY MEDICAL CONDITIONS NOT ON THIS FORM THAT THE DOCTOR SHOULD BE MADE AWARE OF PRIOR TO DENTAL TREATMENT, IF YES PLEASE EXPLAIN:_____

_____

To the best of my knowledge the above information is accurate.

_____ _____ _____

Patient's Signature **Date** **Doctor's Signature**