MEDICAL HISTORY

PATIENT NAME	MEDICAL ALERT

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what?_____
   Physician's Name_____ Phone_____
   Address_____ City_____ State_____ Zip_____

2. Are you currently taking **ANY** prescription medications or over the counter medications? ..... Yes No
   If yes, please list name and dosage_____
   _____
   _____

3. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No
   If yes, please list: _____

4. Have you been a patient in the hospital during the past five years? ..... Yes No

5. Indicate which of the following you have had, or have at the present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Yellow Jaundice	Yes	No	Allergies or Hives	Yes	No
Chest Pain	Yes	No	Arthritis/Rheumatism	Yes	No	Sinus Trouble	Yes	No
Congenital Heart Disease	Yes	No	Cortisone Medicine	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Swollen Ankles	Yes	No	Chemotherapy	Yes	No
High Blood Pressure	Yes	No	Diet (Special/Restricted)	Yes	No	Tumors	Yes	No
Mitral Valve Prolapse	Yes	No	Kidney Trouble	Yes	No	Venereal Disease	Yes	No
Artificial Heart Valve	Yes	No	Ulcers	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Pacemaker	Yes	No	Diabetes	Yes	No	Blood Transfusion	Yes	No
Rheumatic Fever	Yes	No	Thyroid Problems	Yes	No	Hemophilia	Yes	No
Stroke	Yes	No	Glaucoma	Yes	No	Sickle Cell Disease	Yes	No
Artificial Joints (hip knee, etc.)	Yes	No	Contact lenses	Yes	No	Bruise Easily	Yes	No
Latex Sensitivity	Yes	No	Emphysema	Yes	No	Neurological Disorders	Yes	No
Hepatitis A (infectious) B (serum)	Yes	No	Chronic Cough	Yes	No	Epilepsy or Seizures	Yes	No
A.I.D.S.	Yes	No	Tuberculosis	Yes	No	Fainting or Dizzy Spells	Yes	No
H.I.V. Positive	Yes	No	Asthma	Yes	No	Nervous/Anxious	Yes	No
Liver Disease	Yes	No	Hay Fever	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____

8. ***Women.*** Are you: ***Pregnant?*** Yes,____ Months No ***Nursing?*** Yes No ***Taking birth control pills?*** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

*Patient/Guardian Signature*_____ *Date*_____