MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both the dental and medical history form.

All information is completely confidential.

Patient Name_____ **Health Alert**_____ BP:

1. Have you been under the care of a medical doctor during the past 2 years? . . . Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____

2. Have you taken any medication/drugs during the past 2 years? Yes No

3. Are you taking any medication, drugs, or pills now? ..... Yes No
   If yes, please list name and dosage: _____

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

5. Have you been a patient in the hospital during the past 5 years? Yes No

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

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

7. Do you use more than two pillows to sleep? ..... Yes No

8. Have you lost or gained more than 10 pounds in the last year? . . . . Yes No

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

10. 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 & efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have may permission to ask the 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. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge will be added to any balance over 30 days In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs & reasonable attorney fees as may be required to effect collection of this note

Patient/Guardian Signature_____ Date _____

History Review

Doctor Signature_____ Date_____