MEDICAL HISTORY FORM

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Name: ____

Height: ________________ **Weight:** ____________ **Age:** ________________

How is your current physical health? □ **Good** □ **Fair** □ **Poor**

Physician's Name, Address, and Phone Number: ____

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When were you last seen by a doctor? _________________ **Why?** ______________________________

Please give the name and dosage of all current medications:______________________________

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Please indicate if you are allergic to any of the following medications by checking the corresponding box:

- □ Penicillin, Amoxicillin
- □ Tetracycline, Doxycycline, Vibramycin
- □ Sulfa Drugs
- □ Aspirin
- □ Ibuprofen, Motrin
- □ Codeine
- □ Narcotics, Demerol
- □ Local Anesthetics
- □ Latex
- □ Other: ________________

Please indicate any of the following conditions by checking off the corresponding box:

- □ Heart Problems
- □ Heart Condition or Murmur
- □ Atrial Fibrillation
- □ Artificial Heart Valve/Pacemaker
- □ High Blood Pressure
- □ Stroke
- □ Artificial Joints (Hips, Knee, Etc.)
- □ Kidney Trouble
- □ Ulcers/Stomach Problems
- □ Diabetes
- □ Family Member with Diabetes
- □ Excessive or Abnormal Bleeding
- □ Thyroid Problems
- □ Anemia/Sickle Cell Anemia
- □ Glaucoma
- □ Arthritis
- □ Immune System Disorders
- □ Tobacco Use
- □ Tuberculosis
- □ Asthma/Emphysema/Bronchitis
- □ Sinus Problems/Allergies
- □ Radiation Therapy/Chemotherapy
- □ Tumors, Cancer, Malignancies
- □ Hepatitis A, B, C
- □ AIDS/HIV Positive
- □ Venereal Disease/STD
- □ Liver Disease
- □ Severe Headaches
- □ Neurological Disorder
- □ Epilepsy or Seizures
- □ Fainting or Dizzy Spells
- □ Psychiatric/Psychological Care
- □ Alcohol/Drug Use
- □ Restless Leg Syndrome
- Women: □ Pregnant or Nursing

Please list any previous surgeries and dates **or** **select NONE** ___________

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Indicate which of the following you have had or have at the present. **Circle yes or no**

- Have you had any serious trouble associated with any previous dental treatment? .... **Yes** **No**
  If yes, explain: ______________________________
- Are you required to restrict your activity or diet? .... **Yes** **No**
  If yes, why? ______________________________
- Do you have any disease, condition, or problem not listed above that you think I should know about?........ **Yes** **No**
  If yes, please list: ______________________________

Emergency Contact: ______________________________

Phone: ________________________ Relationship to patient: ________________________

______________________________ ______________________________

Signature **Date**