

# MEDICAL HISTORY

Date \_\_\_\_\_ SS/HIC/Patient ID# \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Check (✓) if you have or have had problems with any of the following:

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma or Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles or mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Nasal Obstruction	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (✓) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

	Presently Taking	Taken in the Past	History of Reaction		Presently Taking	Taken in the Past	History of Reaction		Presently Taking	Taken in the Past	History of Reaction	
Anesthetics, Locally Injected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone or Other Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin or Diabetes Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anesthetics, General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coumadin, Heparin, Warfarin or other blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives or Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dilantin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Pills (Barbiturates)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-anxiety Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diuretics (water pills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-depressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tylenol (Acetomeniphen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Medications such as Digoxin, Nitroglycerin or Digitalis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to any other medication or drug	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Daily Aspirin Regimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen (Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please specify _____				
Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Blood Pressure Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Codeine, Demerol or Other Analgesics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

Medication	Condition	Prescribing Doctor
_____	_____	_____
_____	_____	_____

Pharmacy Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Women: Are you pregnant?  Yes  No Nursing?  Yes  No Have you had any serious illnesses or surgeries?  Yes  No If yes, describe \_\_\_\_\_

Check (✓) your current use of:

Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No
Packs per day	_____
Alcohol, Beer, Wine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drinks per day	_____
Street Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Times per day	_____
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cups per day	_____
High Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason	_____

Do you have any other health needs you should bring to our attention? \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient