# MEDICAL HISTORY

☐ Male
☐ Female

PATIENTS NAME_____
Last First Initial Date of Birth

WRITE IN OR CIRCLE THE APPROPRIATE ANSWER. Yes (Y) or No (N)

Physician (name)_____

Location/ phone number_____

Y/N Are you under a physicians care? If yes, explain_____

Y/N Have you ever had a serious illness or major surgery? If yes, explain_____

When was your last physical exam?_____

Y/N Are you pregnant or do you suspect you may be?
If yes, due date_____
Y/N Do you use birth control pills?

Y/N Have you ever taken PhenFen? Or Redux?

Y/N Are you taking any medication or substance? List all.

_____

_____

_____

**(For staff use only)**
Notes for initial completion of form.

| Premed | Med Alert |
|---|---|
| | |
| **Allergic to** | **Anesthetic** |
| | |

**Are you allergic to or had a reaction to:**

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics | Y / N | Anesthetic | Y / N | Latex | Y / N |
| Penicillin | Y / N | Codeine | Y / N | Metals | Y / N |

Other medications or substances (list)_____

_____

**Do you have or have you had:**

| | | | | | |
|---|---|---|---|---|---|
| Heart disease | Y / N | Asthma | Y / N | Stomach problems | Y / N |
| A pacemaker | Y / N | Tuberculosis | Y / N | Kidney problems | Y / N |
| High or low blood pressure | Y / N | Positive mantoux test | Y / N | Liver problems | Y / N |
| Heart murmurs | Y / N | Venereal disease | Y / N | Radiation Treatment | Y / N |
| Rheumatic/ scarlet fever | Y / N | AIDS/ HIV | Y / N | Chemo treatment | Y / N |
| An artificial heart valve implant | Y / N | Hepatitis | Y / N | Chemical dependency | Y / N |
| Artificial joints/ prosthesis | Y / N | Arthritis or rheumatitis | Y / N | Mental healthcare | Y / N |
| Diabetes | Y / N | Anemia/leukemia | Y / N | Eating disorders | Y / N |
| Epilepsy/ seizure disorder | Y / N | Abnormal bleeding | Y / N | Use tobacco products | Y / N |

Have you ever been advised to be premedicated prior to dental treatment? Y / N (If yes, reason)_____

_____

Is there anything else we should know about your health that is not covered in this form? Y/N (If yes, please explain)_____

_____

The above information is correct to my knowledge. I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize payment of medical/dental benefits to undersigned dentist for services prescribed/performed.

**PATIENT'S/ GUARDIAN'S SIGNATURE**_____ **DATE**_____

DDS SIGNATURE_____ DATE_____