MEDICAL HISTORY
Patient Name: _____

Please answer each question. Circle Yes or No where applicable:

1. Are you in good health?..... Yes No
2. Date of last physical exam _____
3. Physician's Name: _____ Phone # _____
4. Have you had any serious operations or been hospitalized?..... Yes No
   If yes, Please Explain? _____
5. Are you taking any medication? ..... Yes No
   If yes, please list: _____
6. Are you using any recreational drugs (marijuana, cocaine, etc.)?..... Yes No
   If yes, what? _____
7. Are you **sensitive** or **allergic** to any drugs or medications? ..... Yes No
   ☐Amoxicillin ☐Aspirin ☐Codeine ☐Dental Anesthetics ☐Erythromycin ☐Keflex
   ☐Latex ☐ Penicillin ☐Sulfa Drugs ☐Tetracycline ☐ Other, please list them:
   _____

Please check any of the following you may have or have had in the past:

☐ Anemia	☐ Emphysema	☐ Kidney Problems	☐ Tuberculosis
☐ Angina Pectoris	☐ Epilepsy	☐ Liver Disease	☐ Ulcers
☐ Arthritis	☐ Excessive Bleeding	☐ Mental Disorders	☐ Venereal Disease
☐ Artificial Prosthesis	☐ Fainting Spells	☐ Mitral Valve	☐ Other _____
☐ Asthma	☐ Glaucoma	☐ Nervous Disorders	_____
☐ Blood Disease	☐ Head Injuries	☐ Pace Maker	_____
☐ Blood Transfusion	☐ Heart Attack	☐ Psychiatric Problems	
☐ Bruise Easily	☐ Heart Failure	☐ Radiation Therapy	
☐ Cancer/Chemo	☐ Heart Lesions	☐ Respiratory Disease	
☐ Cerebral Palsy	☐ Heart Murmur	☐ Rheumatic Fever	
☐ Cold Sores	☐ Hemophilia	☐ Scarlet Fever	
☐ Cortisone Medication	☐ Hepatitis	☐ Sickle Cell Disease	
☐ C-Pap Machine	☐ Herpes	☐ Sinus Problems	
☐ Diabetes	☐ High Blood Pressure	☐ Stroke	
☐ Difficulty Swallowing	☐ HIV/Aids	☐ Taken Fen-Phen	
☐ Drug Abuse	☐ Joint Replacement	☐ Thyroid Problems	

8. **Do you need antibiotic pre-medication for your dental treatment? ..... Yes No**
9. Do you have or have you have any disease, condition, or problem not listed? Yes No
   If Yes, Please List: _____
10. Do you smoke? ..... Yes No
    If Yes, how many per day? _____

11. **WOMEN**: Are you pregnant or think you could be Pregnant? ..... Yes No
    If Yes, How many months? _____ Nursing? Yes No
12. **WOMEN**: Do you use birth control prescriptions? ..... Yes No

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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 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.

Patient/Guardian Signature: _____ Date: _____

Health History Updates

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any changes in my health, or medications, I will, without fail, inform the doctors at my next appointment.

Year 1: Date: _____
Health Changes: _____
_____
_____
_____
Physician's Name _____
Physician's Phone _____
Patient Signature _____ Staff Initials _____

Current Medications:
_____
_____
_____
_____

Year 2: Date: _____
Health Changes: _____
_____
_____
_____
Physician's Name _____
Physician's Phone _____
Patient Signature _____ Staff Initials _____

Current Medications:
_____
_____
_____
_____

Year 3: Date: _____
Health Changes: _____
_____
_____
_____
Physician's Name _____
Physician's Phone _____
Patient Signature _____ Staff Initials _____

Current Medications:
_____
_____
_____
_____