

# MEDICAL HISTORY

NAME \_\_\_\_\_  
Last First MI Date

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

1. Physicians name \_\_\_\_\_  
Address \_\_\_\_\_
2. Have you ever had a serious illness or operation?.....Yes No  
If so, explain \_\_\_\_\_
3. Are you under a physicians care?..... Yes No
4. Are you taking any prescription or over the counter medications? Yes No  
List Medications \_\_\_\_\_
5. Are you allergic to any medications?.....Yes No  
List Medications \_\_\_\_\_
6. Do you have any heart problems ? ..... Yes No
7. Do you have a pacemaker or artificial valve? ..... Yes No
8. Do you have a heart murmur or Mitral Valve Prolapse?..... Yes No
9. Have you ever had rheumatic fever?..... Yes No
10. Have you ever had surgery, radiation treatment, for a tumor,  
growth or other condition?..... Yes No
11. Do you have high or low blood pressure?..... Yes No
12. Do you have any artificial joints or prosthesis?..... Yes No
13. Do you have anemia, leukemia , etc ?..... Yes No
14. Do you bleed excessively after being cut?..... Yes No
15. Do you have any stomach problems ? ..... Yes No
16. Do you have any liver problems ?..... Yes No
17. Do you have any kidney problems? ..... Yes No
18. Are you diabetic?.....Yes No
19. Do You have asthma?.....Yes No
20. Do you have epilepsy or seizure disorders?.....Yes No
22. Are you HIV positive or do you have AIDS?..... Yes No
23. Do you have or have you ever had hepatitis?.....Yes No
24. Do you have or have you had T.B.? .....Yes No
25. Do you smoke?.....Yes No
26. Do you consume alcoholic beverages?.....Yes No
27. Women- are you pregnant or suspect you may be?.....Yes No
28. Do you have any disease, condition, or problem not listed above?  
If so, explain \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist/Hygienist signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE FILL OUT DENTAL HISTORY ON THE BACK