# MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

| | | | | | |
|---|---|---|---|---|---|
| Adenoids removed | Yes | No | Hemophilia | Yes | No |
| Tonsils removed | Yes | No | Hepatitis | Yes | No |
| Tonsil issues | Yes | No | Hypoglycemia | Yes | No |
| Anemia | Yes | No | Immune system disorder | Yes | No |
| Arteriosclerosis | Yes | No | Insomnia | Yes | No |
| Asthma | Yes | No | Intestinal disorders | Yes | No |
| Autoimmune disorders | Yes | No | Jaw joint surgery | Yes | No |
| Bleeding easily | Yes | No | Joint replacement | Yes | No |
| Blood Pressure | Yes | No | Kidney problems | Yes | No |
| Breathe through mouth | Yes | No | Liver disease | Yes | No |
| Bruising easily | Yes | No | Meniere's disease | Yes | No |
| Clenching, grinding | Yes | No | Multiple sclerosis | Yes | No |
| Cancer | Yes | No | Muscle aches | Yes | No |
| Chemotherapy | Yes | No | Muscle shaking (tremors) | Yes | No |
| Chronic Fatigue | Yes | No | Muscle spasms or cramps | Yes | No |
| Cold hands & feet | Yes | No | Muscular dystrophy | Yes | No |
| Depression | Yes | No | Nervousness | Yes | No |
| Diabetes | Yes | No | Neuralgia | Yes | No |
| Difficulty concentrating | Yes | No | Osteoarthritis | Yes | No |
| Dizziness | Yes | No | Osteoporosis | Yes | No |
| Emphysema | Yes | No | Parkinson's disease | Yes | No |
| Excessive thirst | Yes | No | Prior orthodontic treatment | Yes | No |
| Fluid retention | Yes | No | Psychiatric care | Yes | No |
| Frequent cough | Yes | No | Radiation treatment | Yes | No |
| Frequent illnesses | Yes | No | Rheumatic fever | Yes | No |
| Frequent stressful situations | Yes | No | Rheumatoid arthritis | Yes | No |
| Issues with general anesthesia | Yes | No | Scarlet fever | Yes | No |
| Glaucoma | Yes | No | Shortness of breath | Yes | No |
| Gout | Yes | No | Sinus problems | Yes | No |
| Hay Fever | Yes | No | Skin disorder | Yes | No |
| Hearing impairment | Yes | No | Slow healing | Yes | No |
| Heart murmur | Yes | No | Snore at night | Yes | No |
| Heart disorder | Yes | No | Speech problems | Yes | No |
| Heart pacemaker | Yes | No | Stroke | Yes | No |
| Heart palpitations | Yes | No | Swollen, or painful joints | Yes | No |
| Heart valve replacement | Yes | No | Tuberculosis | Yes | No |

Dentist Initials: _____ Date _____

## MEDICAL HISTORY

**Have you ever had an allergic reaction to any of the following? Please list.**

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics | Yes | No | Local anesthetics | Yes | No |
| Aspirin | Yes | No | Penicillin | Yes | No |
| Barbiturates | Yes | No | Plastics | Yes | No |
| Codeine | Yes | No | Sedatives | Yes | No |
| Gluten | Yes | No | Sulfa Drugs | Yes | No |
| Metals | Yes | No | Other List: | Yes | No |
| Iodine | Yes | No | _____ | | |
| Latex | Yes | No | _____ | | |

**Women**

**Are you pregnant or think you may be pregnant? Yes No _____ Months**

**Nursing? Yes No**

**List any medications prescription, OTC, and Supplements**

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Family Physician:** _____

**Address:** _____

**Phone:** _____

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 dentist of any changes in my health or medication.

_____ _____

(Patient/Guardian Signature) (Date)

**History Review/Update:**

| Date | Changes Noted | Intial Line |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Dentist Initials: _____ Date _____