MEDICAL HISTORY

Patient's Name_____**DOB**_____**SSN**_____

INSTRUCTIONS:
To receive treatment in this office you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given. If you are unsure of the question, unsure of you answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor. Some of the questions may not relate to your medical condition; in that event you are to write "N/A" (not applicable) in the space provided. All questions must be answered. To properly evaluate you current health status it may be necessary for the dentist to contact your physician. Included on this from is "Permission To Release Information." Please sign it in the presence of a member of the office staff.

Medical Alert Sticker

ALL INFORMATION YOU SUPPLY ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOU WRITTEN PERMISSION.

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1. **Name, address & telephone # of you physician**_____
   _____
2. **Date of last visit to your doctor** _____**Purpose of visit**_____
3. **Do you suffer from any disability?** _____**If yes, describe**_____
   _____
4. **Have you ever, or do you now take illegal drugs?** _____**If yes, what drugs, and when taken?**
   _____
   _____*Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.*
5. **Do you have AIDS, or are you HIV-positive?** _____**If yes, describe and provide current status.**
   _____
6. **Do you now have, or have you ever had a venereal disease?** _____**If yes, describe,**
   _____
7. **Have you ever had, or do you now have hepatitis?** _____**If yes, describe.** _____
8. **For females: Are you pregnant?** _____**If yes, when are you due?** _____
9. **For females: Are you taking birth control pills?** _____*Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills?*
10. **Are you taking any drugs or medications?** _____**If yes, list and describe amounts and purpose.**
    _____
    Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.
11. **Have you ever had an allergic reaction to medication?** _____**If yes, describe.** _____
    _____
12. **Have you lost weight recently?** _____**If yes, describe.** _____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

13. **Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?** _____
    _____
14. **Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?** _____
    _____
15. **Stomach or intestinal disease?** _____
    _____
16. **Abnormal blood pressure, excessive bleeding, or anemia?** _____
    _____

17. **Breathing problems, asthma, tuberculosis, or hay fever**_____

18. **Cancer, X-ray treatments, or chemotherapy?** _____

19. **Diabetes?** _____

20. **Kidney problems or renal dialysis?** _____

21. **A stroke, convulsions, or fainting spells?** _____

22. **Tumors or growths?** _____

23. **Arthritis or rheumatism?** _____

24. **Have you ever had a major operation? If yes, describe.** _____

25. **Have you ever had a serious injury to your head or neck? If yes, describe.** _____

26. **Are you on a special diet? If yes, for what reason and describe.** _____

27. **Do you smoke? If yes, describe type and quantity.** _____

28. **Have you consulted or been treated by a psychiatrist, psychologist or counselor? If yes, describe.**

29. **Are there any other problems about your health of which you are aware?** _____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form

Permission to release health information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

Person completing the form: **Signature**_____

_____ **Print Name**_____

If other than patient, indicate relationship_____**Date**_____

Dentist's History Review & Significant Findings

_____

_____

_____

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_____

_____

Signature Dr. _____**Date**_____