MEDICAL HISTORY FORM

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Name: ______________________________

Height: ______________ Weight: ______________ Age: ______________

How is your current physical health? ☐ Good ☐ Fair ☐ Poor

Physician's Name: ______________________________

____

When were you last seen by a doctor? ______________ Why? ______________

Please give name and dosage of current medications: ______________

______________ ______________ ______________

______________ ______________ ______________

Please indicate if you are allergic to any of the following medications by checking the corresponding box:

- ☐ Penicillin, Amoxicillin
- ☐ Erythromycin
- ☐ Tetracycline, Doxycycline, Vibramycin
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Ibuprofen, Motrin
- ☐ Codeine
- ☐ Narcotics, Demerol
- ☐ Barbiturate, Sedatives
- ☐ Local Anesthetics
- ☐ Latex
- ☐ Other: ______________

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Heart Problems
- ☐ Heart Condition or Murmur
- ☐ Artificial Heart Valve/Pacemaker
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Artificial Joints (Hips, Knee, Etc.)
- ☐ Kidney Trouble
- ☐ Ulcers/Stomach Problems
- ☐ Diabetes
- ☐ Family Member with Diabetes
- ☐ Excessive or Abnormal Bleeding
- ☐ Thyroid Problems
- ☐ Anemia/Sickle Cell Anemia
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Immune System Disorders
- ☐ Tuberculosis
- ☐ Asthma/Emphysema/Bronchitis
- ☐ Sinus Problems/Allergies
- ☐ Radiation Therapy/Chemotherapy
- ☐ Tumors, Cancer, Malignancies
- ☐ Hepatitis A, B, C
- ☐ AIDS/HIV Positive
- ☐ Venereal Disease/STD
- ☐ Liver Disease
- ☐ Severe Headaches
- ☐ Neurological Disorder
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Psychiatric/Psychological Care
- ☐ Alcohol/Drug Use
- Women: ☐ Pregnant or Nursing

Indicate which of the following you have had or have at the present. Circle yes or no

Have you had any serious trouble associated with any previous dental treatment?………………………… yes no

If yes, explain: ______________________________

Are you required to restrict your activity or diet?………………………………………………………….... yes no

If yes, why? ______________________________

Do you have any disease, condition, or problem not listed above that you think I should know about?……. yes no

If yes, please list: ______________________________

Emergency Contact: ______________________________

Phone: ______________ Relationship to patient: ______________

______________________________ ______________

Signature **Date**