

MEDICAL HEALTH HISTORY

Name: _____ Date: _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____

Please mark yes or no if you have or have had any of the following:

Heart Murmur (mitral valve prolapse)	No	Yes	Latex Sensitivity	No	Yes
Anemia	No	Yes	H.I.V. Infection/AIDS	No	Yes
Diabetes	No	Yes	Cancer, Osteoporosis, Multiple Myeloma	No	Yes
Epilepsy	No	Yes	Do you consume any form of grapefruit?	No	Yes
Hepatitis, Any Form	No	Yes	Are you taking Tagamet (Cimetidine)?	No	Yes
Rheumatic Fever	No	Yes	Do you take antacids?	No	Yes
Asthma	No	Yes	Are you allergic to or have you had a reaction to:		
HIV Positive or AIDS Related Complex	No	Yes	Local Anesthetics?	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Penicillin?	No	Yes
Abnormal Heart Condition	No	Yes	Aspirin?	No	Yes
Kidney Disease	No	Yes	Codeine, Valium or other sedatives?	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Are you a smoker? If yes, How much per day?	No	Yes
Psychosis	No	Yes	Abnormal Blood Pressure? Please indicate. /S /D	No	Yes
Sore/Enlarged Lymph Nodes	No	Yes	Are you required to premedicate before dental treatment?	No	Yes
Previous Biopsies	No	Yes	Do you/have you ever take Fosamax, Actonel or Boniva?	No	Yes
Slow Healing Mouth Sores	No	Yes	If yes, please indicate how long:		
Other Infections	No	Yes	Are you taking any herbal supplements?	No	Yes
Recurrent Illnesses	No	Yes	Other:		
Joint Replacement	No	Yes			
Glaucoma	No	Yes	Women: Are you pregnant?	No	Yes
Abnormal Bleeding from a cut	No	Yes	If no, are you planning a pregnancy in the near future?	No	Yes
Liver Disease (including Jaundice)	No	Yes	Are you a nursing mother?	No	Yes
Unintentional Weight Loss/Gain	No	Yes	Are you taking birth control pills?	No	Yes

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Weight: _____

Diet: Restricted Diet _____

How many meals a day _____

Food Allergies _____

Sugar in your diet None Slight Moderate High

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 change in my health and medication.

Patient (Print Name)

Patient Signature

Date