MEDICAL HISTORY

Patient Name _____ DOB_____ Date _____

Physician_____ Date of Last Visit_____
PCP Address_____ PCP Phone _____

PLEASE CIRCLE YES OR NO. IF YES, PLEASE EXPLAIN.

Yes No Have seen a physician in the last 12 months? Why? _____
_____

Yes No Are you taking any medications? Please list:_____
_____
_____

Yes No Do you have allergies to materials or medications? _____
_____

Yes No Have you had any operations? _____

Yes No Have you ever been involved in a serious accident with a head or neck injury?_____
_____

Yes No Have you ever smoked or chewed tobacco, or used other drugs? _____

FEMALE PATIENTS ONLY:

Yes No Are you using birth control / oral contraceptives? _____

Yes No Are you pregnant? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding / Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Artificial Joints	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Arthritis	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Asthma or Hayfever	Heart Problems	Kidney Disease	Stroke
Bone Disorders	Heart Murmur	Nervous Disorders	Tuberculosis
Congenital Heart Defect	Heart Attack	Pacemaker	Tumor or Cancer

Are there any medical conditions you have that are not listed?_____
_____
_____

Comments about your medical conditions?
_____
_____
_____

Patient / Guardian's Signature _____ Date _____

Relationship to Patient _____

To properly evaluate your health status, it may be necessary for the dentist to contact your physician. This document acts as a **"Medical History Permission Release"** form. ALL INFORMATION YOU SUPPLY ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR WRITTEN PERMISSION.