MEDICAL and/or DENTAL CLINIC MEDICAL HISTORY

PATIENT NAME: _____

Do you have a history of any of the following? (Check all that apply)

	Y	N		Y	N
Allergic to local anesthetic			Arthritis		
Blood/Clotting Disorders			Depression		
Hardening of the Arteries			Skin Disease		
Chest Pain			Prosthetic Joint/Valves		
Swollen Ankles			Chemo/Radiation therapy		
High Blood Pressure			Bisphosphonate therapy		
Heart Problems			Cancer		
Heart Murmur			Anemia		
Rheumatic Heart Disease/Fever			Seizures		
Stroke			Latex Allergy		
Prolonged Bleeding			Steroid Medication		
Tuberculosis			Organ Transplant		
Emphysema			Urinary Tract Problems		
Fainting/Dizziness			Recreational Drug Use		
Ear/Nose/Throat Problems			Vision Problems		
Frequent Headaches			Asthma		
Hearing Problems			Aspirin therapy		
Kidney Disease			Persistent Cough		
Diabetes			Seasonal Allergies		
Thyroid Disease			Chronic Mental Illness		
Liver Disease			Glaucoma		
Hepatitis			Surgery with Rods/Pins/Screws		
Sexually Transmitted Disease			Allergy to Medication		
HIV/AIDS			Other:		
Shortness of Breath					
Stomach/Intestinal Problems					

CURRENT MEDICATIONS

Are you pregnant? Y☐ N☐ Do you drink alcohol? Y☐ N☐
Are you nursing? Y☐ N☐ Do you use tobacco? Y☐ N☐
Do you have any disease not listed? Y☐ N☐
If yes, please explain: _____

Has Any Blood Relatives Suffered Any of the Following:
(**CHECK WHICH ILLNESS & INDICATE WHICH RELATIVE**)

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Lung Disease ☐ Glaucoma
☐ Cancer ☐ Diabetes ☐ Asthma ☐ Seizures
☐ Blood Disease ☐ Kidney Disease ☐ Sickle Cell ☐ Migraine

Any Disease of Reproductive Organs?

Males (Prostate, Testicles, Penis) ☐ Yes ☐ No
Females (Uterus, Ovaries, Cervix) ☐ Yes ☐ No
If Yes, please specify: _____

When Were You Last Immunized Against…

Tetanus? _____ Pneumonia? _____

OB History (WOMEN ONLY)

Number Of Pregnancies _____ Number of Living Children _____
Date of Last Menstrual Period _____ Diabetes or Blood Pressure _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of her/his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient/Guardian Date