MEDICAL HISTORY

PATIENT NAME_____ DATE_____

MEDICAL DOCTOR NAME_____ CLINIC NAME, ADDRESS, & PHONE NUMBER_____

_____

PHARMACY NAME & PHONE NUMBER _____

IN CASE OF EMERGENCY, CONTACT: _____ PHONE _____

LIST OF MEDICATIONS/DOSAGE & FREQUENCY (PRESCRIPTION AND OVER THE COUNTER): **PLEASE BRING A LIST IF THERE ARE MANY .**

ALLERGIES: (PLEASE CIRCLE) AMOXICILLIN ASPIRIN CODIENE DENTAL ANESTHETIC ERYTHROMYCIN

JEWELRY KEFLEX LATEX METALS PENICILLIN SULFA TETRACYCLINE ZITHROMAX OTHER _____

FEMALES ARE YOU?:__TAKING BIRTH CONTROL
____NURSING ____PREGNANT_____ # OF WKS

TOBACCO USE: DO YOU?:
SMOKE_____ CHEW _____

HAS YOUR PHYSICIAN TOLD YOU TO"PRE-MEDICATE" PRIOR TO DENTAL TREATMENTS___Y ___N
WHAT PRE-MEDICATION HAS BEEN PRESCRIBED FOR YOU IN THE PAST_____

IF PATIENT HAS A HEALTH HISTORY OF ANY OF THE FOLLOWING: PLEASE CIRCLE

Abnormal Bleeding Hemophilia	Cancer Chemotherapy	Epilepsy	High Blood Pressure	Psychiatric Problems	Venereal Disease
Alcohol Abuse	Cerebral Palsy	Fever Blisters	Kidney Problems	Radiation Therapy	Other:
Allergies/ Hay Fever	Colitis	Frequent Headaches	Leukemia	Rheumatic Fever	
Arthritis	Congenital Heart Defect	Glaucoma	Liver Disease	Seizures	
Anemia Sickle Cell Disease	COPD	Heart Attack	Low Blood Pressure	Shingles	
Artificial Joint Prosthesis	Coronary Artery Disease	Heart Murmur	Low Blood Sugar	Sinus Problems	
Artificial Heart Valve	Diabetes	Heart Problems Angina	Mitral Valve Prolapse	Stomach Problems	
Asthma /Difficulty Breathing	Dizziness	Heart Surgery	Osteoporosis/ Paget's Disease	Stroke	
Birth Defects	Drug Abuse	Hepatitis A B C	Pacemaker	Thyroid Problems	
Blood Transfusions	Emphysema	HIV+/Aids	Pneumocystitis	Tuberculosis	
	Fainting				

SENSORY PROBLEMS: EYESIGHT HEARING SPEECH TOUCH TASTE

LEARNING PROBLEMS: BEHAVIORAL DISORDER LEARNING DISORDER

MAJOR SURGERIES, OTHER ILLNESSES OR FURTHER EXPLANATION OF ABOVE:

Patient/Parent Signature: _____

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