PATIENT MEDICAL HISTORY

PLEASE PRINT

Last Name _____ First _____ MI _____ Date of Birth ___/___/___

Have you ever had any of the following? Please circle Y (Yes) or N (No):

Low blood pressure. . . .Y N	Blood disease. . .Y N	Nerves. . . . . .Y N
High blood pressure. . . .Y N	Hepatitis. . . . . .Y N	Tumors. . . . . Y N
Heart problems. . . . . .Y N	Epilepsy. . . . . .Y N	Growths. . . . . .Y N
Lung disorders. . . . . Y N	Asthma. . . . . .Y N	Anemia. . . . . Y N
Liver disease. . . . . Y N	Allergies. . . . . .Y N	Diabetes. . . . . .Y N
	Rheumatic fever. . . . . .Y N	

Are you allergic to any of the following drugs? Please circle:

Penicillin Aspirin Erythromycin Tetracycline Codeine Latex
Dental Anesthetics Other _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor.

Are you currently under the care of a physician? Please explain:

_____

List medications you are now taking:

	Medication	Reason
1.		
2.		
3.		
4.		
5.		

CERTIFICATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services that I may need during diagnosis and treatment.

Signature: _____ Date: _____

FOR DOCTOR'S USE:

MEDICAL HISTORY UPDATE

1. Date ___/___/___ Comments _____ Signature _____
2. Date ___/___/___ Comments _____ Signature _____
3. Date ___/___/___ Comments _____ Signature _____