

# 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:

	<u>Medication</u>	<u>Reason</u>
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 \_\_\_\_\_