MEDICAL HISTORY FOR ADULTS

This information is for a confidential record necessary in providing quality dental care. Please help us by providing the following:

Have you been examined and/or treated by a physician in the last year? __ Yes __ No

Are you taking any medicines, drugs, or pills/herbal remedies now (prescription or over-the-counter)? If so, please list.
____

Are you allergic to any of the medications listed? If so, please circle.

Dental Anesthesia Aspirin Codeine Penicillin Latex

Are you allergic to any other medications? If so, please list. ________________________

Have you been seriously ill or hospitalized? _____ Yes _____ No

If so, for what? ____

____

Have you ever had hepatitis?	Yes	No
Have you had an HIV (Aids) test with positive results?	Yes	No
Have you ever had a blood transfusion?	Yes	No
Do you have any kidney or liver problems?	Yes	No
Have you ever had kidney dialysis?	Yes	No
Have you ever had Rheumatic fever?	Yes	No
Do you have a heart murmur?	Yes	No
Have you ever had a heart attack?	Yes	No
Do you have high blood pressure?	Yes	No
Have you ever had any heart valves replaced?	Yes	No
Do you have Mitral Valve prolapse?	Yes	No
Any other heart problems?	Yes	No
Do you have any hip, knee or other joint replacements?	Yes	No

If so, when were they placed? ____

Please circle any of the following conditions that you have had or have at the present time:

Asthma	Sinus Trouble	Epilepsy	Cancer
Hemophilia	Bleeding Problems	Tuberculosis	Diabetes
Stroke	Chest Pains	Angina Pectoris	Glaucoma
Dizzy Spells	Fainting	Allergies	Chemical Dependency
			* Are you in recovery? ______

Do you have any disease, condition or medical problem not listed above? ___ Yes ___ No

If yes, please explain. ____

Females only - Are you pregnant? _____ Yes _____ No Due Date: ___________

____ ________________________

Patient Signature **Date**

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