Medical History **Patient's Name**_____

Medical Doctor's Name: _____

Is patient under a doctor's care now? Yes No

Has patient been hospitalized during the past 2 years? Yes No

Why: _____

Is patient taking any medications, pills, or drugs? Yes No

Is patient allergic to any medications or substances? Yes No

If yes, what? _____

Does patient have or ever had any of the following?

Heart Trouble	Yes	No	High Blood Pressure	Yes	No	Heart Murmur	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Kidney Trouble	Yes	No
Hepatitis B (Serum)	Yes	No	Excessive Thirst	Yes	No	Chest Pain	Yes	No
Artificial Joints/ Hip	Yes	No	Yellow Jaundice	Yes	No	Lung Disease	Yes	No
Congenital Heart Lesion	Yes	No	Artificial Heart Valve	Yes	No	Heart Surgery	Yes	No
Heart Pacemaker	Yes	No	x-ray or Cobalt Tmt.	Yes	No	Contact Lenses	Yes	No
Parathyroid Disease	Yes	No	Blood Transfusion	Yes	No	Diabetes	Yes	No
Pain in Jaw Joints	Yes	No	Psychiatric Care	Yes	No	Tuberculosis	Yes	No
Shortness of Breath	Yes	No	Fainting or Dizziness	Yes	No	Liver Disease	Yes	No
Thyroid Disease	Yes	No	Hepatitis A (infec.)	Yes	No	Aids	Yes	No
Hypoglycemia	Yes	No	Sickle Cell	Yes	No	Allergies	Yes	No
Cold Sores	Yes	No	Blood Disease	Yes	No	Anemia	Yes	No
Fever Blisters	Yes	No	Scarlet Fever	Yes	No	Hay Fever	Yes	No
Frequent Cough	Yes	No	Emphysema	Yes	No	Drug Addiction	Yes	No
Glaucoma	Yes	No	Rheumatism	Yes	No	Arthritis/ Gout	Yes	No
Bruise Easily	Yes	No	Hemophilia	Yes	No	Nervousness	Yes	No
Venereal Disease	Yes	No	Herpes	Yes	No	Ulcers	Yes	No
Prolonged Bleeding	Yes	No	Chemotherapy	Yes	No	Cancer	Yes	No
Epilepsy or Seizures	Yes	No	Bone Fractures	Yes	No	Operations	Yes	No
Learning Disabilities	Yes	No	Hereditary Problems	Yes	No	Birth Defects	Yes	No

Does patient require medications for dental or other treatment? Yes No

Recently, Has patient had rapid weight loss or weight gain? Yes No

Does patient have any vision, hearing, tasting, or speech difficulties? Yes No

Does patient have or ever had another serious illness not listed above? Yes No

If yes, Please explain in detail: _____

Do you wish to talk to the doctor privately about any problems? Yes No

Females: Are you pregnant? Yes No

The medical dental history I have provided is complete and accurate to the best of my knowledge. Medical histories will be updated annually, Please advise us of any changes.

Patient/ Parent Signature_____ Date_____

Reviewed By _____ (doctor) Date_____