PATIENT NUMBER

PATIENT NAME: M ☐ F: ☐ _____ DATE _____ Day/Month/Year

FAMILY PHYSICIAN'S NAME: _____ PHONE: _____ BIRTHDATE: _____

Please answer all questions with ✔ or ✘

	YES	NO
1. Have you ever been hospitalized?	☐	☐
2. Have you been under physician's care the past 2 years? Date of last last physical exam:	☐	☐
3. Are you taking any medication, drugs or pills? If yes, please list:	☐	☐
4. Have you ever taken cortisone?	☐	☐
5. Have you ever had Cobalt or Radiation Treatment ?	☐	☐
6. Have you ever received Chemotherapy?	☐	☐
7. Are you allergic to any medication, substances or latex?	☐	☐
8. Do you have any problems with antibiotics or anesthetics?	☐	☐
9. Do you have chest pain or shortness of breath?	☐	☐
10. Have you lost or gained more than 10 lbs. in the past year?	☐	☐
11. Do you ever wake up from sleep short of breath?	☐	☐
12. Are you on a special diet?	☐	☐
13. Has your medical doctor ever diagnosed cancer or a tumor?	☐	☐
14. Would you like to speak to the doctor privately?	☐	☐
15. Have you ever had and/or been treated for any of the following:	☐	☐

DOCTOR'S COMMENTS

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Blood Transfusion	☐	☐	Glaucoma	☐	☐
Heart Disease / Attack	☐	☐	Emphysema / Bronchitis	☐	☐	Liver Disease	☐	☐
Angina Pectoris	☐	☐	Asthma	☐	☐	Hepatitis A / B / C	☐	☐
Heart Failure	☐	☐	Tuberculosis	☐	☐	Yellow Jaundice	☐	☐
Heart Murmur	☐	☐	Hayfever	☐	☐	Leukemia	☐	☐
Congenital Heart Valve	☐	☐	Allergies / Hives	☐	☐	HIV (AIDS)	☐	☐
Mitral Valve Prolapse (MVP)	☐	☐	Sinus Troubles	☐	☐	Veneral Disease	☐	☐
Artificial Heart Valve	☐	☐	Diabetes	☐	☐	Drug Addiction	☐	☐
Rheumatic Fever	☐	☐	Excessive Thirst	☐	☐	Alcohol Dependency	☐	☐
Scarlet Fever	☐	☐	Thyroid Disease	☐	☐	Fainting	☐	☐
Heart Surgery	☐	☐	Arthritis	☐	☐	Nervousness	☐	☐
Heart Pacemaker	☐	☐	Rheumatism	☐	☐	Eating Disorders	☐	☐
Anemia	☐	☐	Prosthetic Joint	☐	☐	Psychiatric Treatment	☐	☐
Excessive Bruising	☐	☐	Kidney Trouble	☐	☐	Epilepsy / Seizures	☐	☐
Hemophilia	☐	☐	Ulcer / Hiatus Hernia	☐	☐	Stroke	☐	☐

16. Is there anything else we should know about your health? _____

FOR WOMEN ONLY	YES	NO
17. Are you pregnant? If yes, in what month?	☐	☐
18. Are you taking birth control pills?	☐	☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I consent to your obtaining, from other practitioners who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care.

PATIENT'S SIGNATURE/: _____ DATE: _____ D.D.S: _____
PARENT OR GUARDIAN

HEALTH ALERT

Medical History