Medical History

Patient Name	Medical Alert	
Physician's Name	Physician's Address	Phone

Reason for last visit to physician:

List any medications you currently take and the dosage:

Have you had an allergic (or adverse) reaction to any drug or substance? If yes, explain

Have you been hospitalized during the past five years? Yes No If so, why?

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Attack or MI	Yes No	Ulcers	Yes No	Hepatitis A (infectious)	Yes No
Date:		Diabetes	Yes No	Hepatitis B (serum)	Yes No
Chest Pain	Yes No	Thyroid Disease	Yes No	Hepatitis C/ or other	Yes No
Congenital Heart Disease	Yes No	Glaucoma	Yes No	A.I.D.S.	Yes No
Heart Surgery	Yes No	Emphysema	Yes No	H.I.V. Positive	Yes No
Date:		Enlarged Prostate	Yes No	Cold Sores/Fever Blisters	Yes No
Infective Endocarditis	Yes No	Tuberculosis	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Asthma	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Hay Fever	Yes No	Sickle Cell Disease	Yes No
Heart Defibulator	Yes No	Latex Sensitivity	Yes No	Bruise Easily	Yes No
Stroke	Yes No	Allergies	Yes No	Liver Disease	Yes No
High Blood Pressure	Yes No	Hives	Yes No	Neurological Disorders	Yes No
Artificial Joints	Yes No	Sinus Infections	Yes No	Epilepsy or Seizures	Yes No
Surgeon's Name:		Cancer	Yes No	Fainting or Dizzy Spells	Yes No
Date of surgery:		Chemotherapy	Yes No	Nervous/Anxious	Yes No
Arthritis/Rheumatism	Yes No	Radiation Therapy	Yes No	Psychiatric Care	Yes No
Swollen Ankles	Yes No	Diet (Special/Restricted)	Yes No	Psychological Care	Yes No
Edema	Yes No	Kidney Disease	Yes No	Recreation drugs	Yes No
Alzheimer's Disease	Yes No	Cortisone Medication	Yes No		

Have you ever taken prescription medications for weight loss?		Yes No
If yes, did you take any of these:	Fen-Phen (Fenfluramine-Phentermine)	Yes No
	Pondimen (Fenfluamine)	Yes No
	Redux	Yes No
If yes, have you had a medical exam for heart issues?		Yes No

Do you have any problem/disease not listed?
If yes, please explain:

Women, are you: Pregnant? Yes, ___ Months No **Nursing:** Yes No **Taking birth control pills?** Yes No

I understand the medical information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the proper health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient (or Guardian) Signature: **Date:**

Do you use any of these drugs/foods/supplements?

Clozapine/Clozaril	Yes No	Alcohol Yes No drinks/day		Hypotension -producing	
Efavirenz (Sustiva)	Yes No	Amiodarone	Yes No	medications	Yes No
Itraconazole	Yes No	Antidepressants:		Isoniazid (INH)	Yes No
Ketoconazole	Yes No	Elavil	Yes No	Levodopa	Yes No
Nefazadone (Serzone)	Yes No	Asendin	Yes No	Mao Inhibiters	Yes No
Protease Inhibitors	Yes No	Anafranil	Yes No	Nicardipine (Cardene)	Yes No
Zidovudine (Retrovir)	Yes No	Doxepin	Yes No	Nifedipine (Adalat)	Yes No
Smoke/chew tobacco?	Yes No	Cimetidine (Tagamet)	Yes No	Paroxetine (Paxil)	Yes No
Packs/day		Contraceptives: oral or		Ranitidine (Zantac)	Yes No
Drink coffee?	Yes No	estrogen containing	Yes No	Sertraline (Zoloft)	Yes No
Cups/day		Cyclosporine	Yes No	Verapamil (Isoptin)	Yes No
Antacids	Yes No	Dilitiazem (Cardiazem)	Yes No	Chamomile	Yes No
Theophylline	Yes No	Ergotamine	Yes No	Kawa (Awa, Tonga)	Yes No
Carpamazepine (Tegretol)	Yes No	Erythromycin	Yes No	Melatonin	Yes No
Rifampin	Yes No	Fluoxetine (Prozac)	Yes No	Valerian (Radix)	Yes No
Schisandra	Yes No	Fluvoxamine (Luvox)	Yes No	**Narrow Angle Glaucoma**	Yes No
St. John's Wort	Yes No	Grapefruit Juice	Yes No		

Weight:

Dentist Signature: **Date:** **ASA I II III IV**