MEDICAL HISTORY

Patient Name:_____

1. Have you been under the care of a medical doctor in the past two years?……..Yes No
   If yes, for what? _____
   Physician's name_____ Phone_____
   Address_____ City_____ State_____ Zip_____
2. Have you taken any medication or drugs in the past two years?…… Yes No
3. Are you taking any medication, drugs or pills now?…….. Yes No
   If yes, please list and name the dosage_____
4. Have you had an allergic or adverse reaction to any medication or substance?……..……. Yes No
   If yes, please list _____
5. Have you been a patient in the hospital in the last five years?……..…… Yes No
6. Indicate of you had, or now have any of the following:

Heart Disease	Yes No	Ulcers	Yes No
Heart Murmur	Yes No	Diabetes	Yes No
High Blood Pressure	Yes No	Thyroid Problems	Yes No
Mitral Valve Prolapse	Yes No	Glaucoma	Yes No
Artificial Heart Valve	Yes No	Respiratory Problems	Yes No
Heart Pacemaker	Yes No	Athsma	Yes No
Rheumatic Fever	Yes No	Allergies or Hives	Yes No
Arthritis/ Rheumatism	Yes No	Tumors or Growths	Yes No
Stroke	Yes No	Chemotherapy	Yes No
Diet (special/ restricted)	Yes No	Radiation Therapy	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Hepatitis A or B	Yes No
Kidney trouble	Yes No	Venereal Disease	Yes No
Neurological Disorders	Yes No	AIDS	Yes No
Epilepsy or Seizures	Yes No	HIV Positive	Yes No
Fainting of Dizziness	Yes No	Cold Sores/ Fever Blisters	Yes No
Bruise Easily	Yes No	Blood Transfusion	Yes No
Sickle Cell Disease	Yes No	Hemophilia	Yes No

7. Have you lost or gained more than ten pounds in the last year?……..……...Yes No
8. Do you have any disease, condition, or problem not listed?…….……Yes No
   If yes, please list _____
9. Women: are you pregnant? Yes__ months__ No Taking birth control pills?……..…Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the 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/ Guardian Signature: Date:

History Review:

Dental Design OF ROCKLAND

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