# MEDICAL HISTORY

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| YOUR PHYSICIAN | TYPE |
| HOW LONG? | OFFICE ADDRESS |
| CITY | STATE |
| ZIP | PHONE NUMBER |

**DO YOU HAVE OR HAVE YOU EVER HAD?**

| | | |
|---|---|---|
| HOSPITALIZATION | YES | NO |
| AN ALLERGIC REACTION | YES | NO |
| **ANY REACTION TO:** | | |
| A. ASPIRIN | YES | NO |
| B. PENICILLIN | YES | NO |
| C. ERYTHROMYCIN | YES | NO |
| D. TETRACYCLINE | YES | NO |
| E. CODEINE | YES | NO |
| F. SEDATIVES OR SLEEPING PILLS (BARBITURATES) | YES | NO |
| G. DENTAL ANESTHETIC | YES | NO |
| H. ANY OTHER MEDICATION | YES | NO |
| HEPATITIS | YES | NO |
| JAUNDICE (YELLOW SKIN AND EYES) | YES | NO |
| EPILEPSY | YES | NO |
| ARTHRITIS | YES | NO |
| VENEREAL DISEASE | YES | NO |
| RHEUMATIC FEVER | YES | NO |
| SCARLET FEVER | YES | NO |
| ANEMIA OR OTHER BLOOD DISORDERS | YES | NO |
| PROLONGED BLEEDING FROM MINOR CUTS | YES | NO |
| KIDNEY DISEASE | YES | NO |
| DIABETES | YES | NO |
| STOMACH OR DUODENAL ULCER | YES | NO |
| LIVER DISEASE | YES | NO |
| TUBERCULOSIS | YES | NO |
| EMPHYSEMA | YES | NO |
| THYROID OR PARATHYROID DISORDERS | YES | NO |
| HEART TROUBLE | YES | NO |
| HEART MURMUR | YES | NO |
| ARTERIOSCLEROSIS | YES | NO |
| HIGH BLOOD PRESSURE | YES | NO |
| LOW BLOOD PRESSURE | YES | NO |
| EXCESSIVELY SWOLLEN ANKLES | YES | NO |
| A STROKE | YES | NO |
| SHORTNESS OF BREATH | YES | NO |
| HIVES, SKIN RASH, HAY FEVER | YES | NO |
| ASTHMA | YES | NO |
| EMOTIONAL PROBLEMS OR TENSION | YES | NO |
| PSYCHIATRIC TREATMENT | YES | NO |
| A TUMOR OR ABNORMAL GROWTH | YES | NO |
| RADIATION TREATMENT BY COBALT, RADIUM X-RAY ETC. | YES | NO |
| GLAUCOMA | YES | NO |
| CONTACT LENSES | YES | NO |
| PROSTATE DISORDERS (IF MALE) | YES | NO |
| BLOOD TRANSFUSIONS | YES | NO |
| SUBSTANCE ABUSE | YES | NO |
| IMMUNE DEFICIENCY SYNDROMES (HIV, AIDS) | YES | NO |

**ARE YOU?**

| | | |
|---|---|---|
| BEING TREATED FOR ANY ILLNESS | YES | NO |
| TAKING MEDICATION REGULARLY | YES | NO |
| AWARE OF A CHANGE IN YOUR GENERAL HEALTH | YES | NO |
| AWARE OF ANY RECENT WEIGHT CHANGE | YES | NO |
| OFTEN THIRSTY | YES | NO |
| URINATING MORE THAN SIX TIMES PER DAY | YES | NO |
| OFTEN EXHAUSTED AND FATIGUED | YES | NO |
| SUBJECT TO FREQUENT HEADACHES | YES | NO |
| A HEAVY SMOKER | YES | NO |
| GENERALLY A NERVOUS PERSON | YES | NO |
| OFTEN UNHAPPY AND DEPRESSED | YES | NO |

**IF FEMALE, ARE YOU NOW?**

| | | |
|---|---|---|
| PREGNANT | YES | NO |
| TAKING BIRTH CONTROL PILLS OR OTHER HORMONES | YES | NO |
| PRESENTLY IN MENOPAUSE | YES | NO |
| PAST MENOPAUSE | YES | NO |

PLEASE EXPLAIN FULLY ANY YES ANSWERS ABOVE:

IF THERE ARE ANY CHANGES IN MY MEDICAL HISTORY, I WILL NOTIFY THE DENTIST.

**PATIENT'S SIGNATURE:**________________________________________

| **REVIEWED BY:** | **DATE:** |
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