

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_

**The following confidential information is essential for this office to provide dental care in a manner that is compatible with your general health. Incorrect or missing information can be dangerous to your health.**

1. Are you currently under the care of a physician? Physician's name \_\_\_\_\_  
If so, for what reason or condition? \_\_\_\_\_
2. Are you currently taking any medication? If yes, list all and the reason for them. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Have you ever had an allergic reaction or other unusual reaction to an anesthetic or medication? If so to what?  
\_\_\_\_\_  
\_\_\_\_\_
4. Are you pregnant? \_\_\_\_\_ If so, what month? \_\_\_\_\_

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Have you **EVER** taken **FOSAMAX** or any other medication for **osteoporosis**? \_\_\_\_\_

**Have you ever had or been treated for:  
(MUST ANSWER EACH ONE YES OR NO)**

Rheumatic Fever	_____	Diabetes	_____	Tumors or Growths	_____
Liver Disease	_____	Asthma	_____	Stomach Problems	_____
Pacemaker	_____	Allergies	_____	Intestine Problems	_____
Heart Murmur	_____	Tuberculosis	_____	Kidney Problems	_____
Mitral Valve Prolapse	_____	Anemia	_____	HIV Positive	_____
Swollen Ankles	_____	Angina	_____	Metal Allergy	_____
High Blood Pressure	_____	Hepatitis	_____	Taken Phen-Fen	_____
Other Heart Problems	_____	Stroke	_____	Joint Replacement	_____
Epilepsy	_____	Convulsions	_____	Osteoporosis	_____
Cancer	_____				

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Are there any other problems about your health of which you are aware? \_\_\_\_\_

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**Note: A change in your health status should be reported to the office at the earliest possible time.**

To the best of my knowledge the foregoing questions have been accurately answered.

Permission to release health information:

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors (insurance company) and/or other health practitioners.

My signature below indicates that I have received a copy of the Dental Materials Fact Sheet and the Notice of Privacy Practices from this office as required by law.

Person completing the form: Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_