Medical History

Medical Alert

Date: ____/____/____
Patient Name:_____
Birth-date: ____/____/____
Physician's Name:_____ Date of Last Physical:____/____/____
Address: _____Telephone:_____
Are you being treated for anything at this time? ☐Yes ☐No
If yes, for what?_____
Have you been told that you needed a pre-medication before dental treatment? ☐Yes ☐No
If yes, for what?_____
Do you have any drug allergies? ☐Yes ☐No
If yes, please list:_____
Have you ever had an adverse reaction to any medication or substance? ☐Yes ☐No
If yes, please list:_____
Have you ever responded adversely to medical or dental treatment? ☐Yes ☐No
If yes, please list:_____
Are you taking any medications at this time? ☐Yes ☐No
If yes, please list medications & dosages:

Medication	Dosage	Medication	Dosage
Medication	Dosage	Medication	Dosage
Medication	Dosage	Medication	Dosage

Do you use Tobacco products? ☐Yes ☐No If yes, how much per DAY? _____
Do you use Controlled Substances or Recreation Drugs? ☐Yes ☐No
If yes, please list:_____
Have you ever had surgery? ☐Yes ☐No If yes, please list:_____
WOMAN ONLY: Are you: Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Birth Control? ☐Yes ☐No
Is there anything else we should know about your medical history? ☐Yes ☐ No If Yes, Explain:

PLEASE CHECK ANY CONDITION YOU HAVE OR MAY HAVE HAD

☐ **AIDS/HIV Positive or Other**	☐ **Chronic Diarrhea**	☐ **Mitral Valve Prolapse**
☐ **Allergies to Anesthetics**	☐ **Circulatory Problems**	☐ **Nervous Problems**
☐ **Allergy to Colored Dyes**	☐ **Contact Lenses**	☐ **Psychiatric Care**
☐ **Allergy to Latex**	☐ **Diabetes**	☐ **Recent Weight Loss**
☐ **Angina Pectoris**	☐ **Epilepsy/Seizures**	☐ **Respiratory Problems**
☐ **Arthritis/Rheumatism**	☐ **General Allergies (list below)**	☐ **Rheumatic Fever**
☐ **Artificial Heart Valves**	☐ **Glaucoma**	☐ **Sinus Problems**
☐ **Artificial Joints**	☐ **Headaches**	☐ **Sleep Apnea**
☐ **Aspirin Taken Daily**	☐ **Heart Disease/Attack**	☐ **Special Diet**
☐ **Asthma**	☐ **Heart Murmur**	☐ **Stroke**
☐ **Autoimmune Disease**	☐ **Heart Pacemaker**	☐ **Swollen Neck Glands**
☐ **Back Problems**	☐ **Hemophilia (bleeding problem)**	☐ **Thyroid Disease**
☐ **Blood Disease**	☐ **High Blood Pressure**	☐ **Tuberculosis**
☐ **Blood Transfusion**	☐ **Hypoglycemia**	☐ **Ulcers**
☐ **Cancer/Leukemia**	☐ **Kidney Problems**	☐ **Venereal Disease**
☐ **Chemical Dependency**	☐ **Low Blood Pressure**	☐ **Other:**_____
☐ **Chemotherapy/Radiation**		

General Allergies: _____

Pharmacy Name:_____ **Phone Number:**_____
Emergency Contact:_____ **Phone Number:**_____

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