



PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Medical History

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone \_\_\_\_\_ Yes No
Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No
Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No
Are you taking any medications, pills or drugs? What? \_\_\_\_\_ Yes No
Are you on a special diet? Discuss \_\_\_\_\_ Yes No
Are you allergic to any medications or substances? Please check box below \_\_\_\_\_ Yes No
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex Rubber [ ] Other \_\_\_\_\_
Women (Please check): [ ] Pregnant/trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives Discuss \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

\*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Disease/Surgery\*, Bruise Easily/Blood Disease, Emphysema, Yellow Jaundice, Cold Sores, etc.

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

Medical Updates

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, REVIEWED BY. Includes rows for signature and date verification.