HEALTH HISTORY

PATIENT NAME_____

MED ALERT

1. Physician's name _____ Phone # _____

2. Are you allergic, or have you reacted adversely, to any of the following? Please circle.

Penicillin	Erythromycin	Clindamycin	Tetracycline	Aspirin
Codeine	Sulfa Drugs	Darvon	Demerol	Mint Flavoring
NSAID's (non Sterioidal anti inflammatory drugs)			Latex	Local Anaesthetic

Other _____

3. Please list all medication you are taking now, *including non-prescription medication* such as vitamins, cold medications, aspirin, Tylenol, antihistamines, herbal remedies, etc.: _____

_____

4. Do you have, or have you experienced, any of the following:

Y N Allergies/Hayfever	***Y N*** Other Liver Disease	***Y N*** Multiple Sclerosis	***Y N*** Psychiatric Disorder
Y N Asthma	***Y N*** Kidney Disease	***Y N*** Parkinson's Disease	***Y N*** Glaucoma
Y N Cold Sores	***Y N*** Artificial Joints	***Y N*** Lupus	***Y N*** AIDS/HIV+
Y N Anemia	***Y N*** Emphysema	***Y N*** Arthritis	***Y N*** Epilepsy
Y N Blood Transfusion	***Y N*** Tuberculosis (TB)	***Y N*** Chronic Fatigue Syndrome	***Y N*** High Blood Pressure
Y N Hemophilia	***Y N*** Other Lung Disease	***Y N*** Sexually Transmitted Disease	***Y N*** Scarlet Fever
Y N Hepatitis A (infectious)	***Y N*** Ulcerative Colitis	***Y N*** Diabetes	***Y N*** Rheumatic Fever
Y N Hepatitis B (serum)	***Y N*** Crohn's Disease	***Y N*** Eating Disorder	
Y N Hepatitis C	***Y N*** Ulcers	***Y N*** Drug Addiction	

Heart Disease:

Y N Angina	***Y N*** Stroke	***Y N*** Heart Murmur
Y N Congestive Heart Failure	***Y N*** Mitral Valve Prolapse	***Y N*** Artificial Heart Valve/Stent
Y N Angioplasty	***Y N*** Pacemaker	***Y N*** Cardiopulmonary Shunt
Y N Heart Attack When _____		

Cancer:

Where? _____ When? _____

Y N Radiation Therapy ***Y N*** Chemotherapy

5. Do you have any disease, condition or problem not listed?	yes	no
6. Do you wish to speak privately to the doctor about any medical condition?	yes	no
7. Have you had a medical examination in the last year?	yes	no
8. Have you been a patient in the hospital in the last 2 years?	yes	no
9. When walking up stairs or taking a walk, do you ever stop because of pain in your chest?	yes	no
10. Do your ankles swell during the day?	yes	no
11. Do you have a tendency to faint?	yes	no
12. Do you have frequent, severe headaches?	yes	no
13. Do you use tobacco?	yes	no
14. Are you pregnant or possibly pregnant? If yes, what month? _____	yes	no
15. Are you breastfeeding?	yes	no

To the best of my knowledge, the questions on this form have been ansered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

_____

Patient Signature **Date**