MEDICAL DENTAL HISTORY FORM

Patient Name:_____ Physician:_____

PreMed Required? Yes No

Allergies to:

Latex: Yes No

Medications _____

Other_____

Reason: _____

Type:_____ Dosage:_____

Current Medications (Prescription, Over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (Check YES for all that apply)

Under physician's care? Details:		Asthma?	
Hospitalization/operation(s) in the last 5 years? Details:		Sleep Apnea?	
Head/neck/mouth injuries?		Tuberculosis?	
Women Pregnant?		Sinus trouble?	
Women Nursing?		Cancer?	
Women: Oral contraceptives?		Radiation treatment to Head/Neck?	
Heart trouble/disease?		Chemotherapy?	
Rheumatic fever?		Kidney Disease?	
Past use of Fenphen?		Dialysis?	
Heart murmur?		Eating Disorder?	
Mitral valve prolapse?		Stomach: reflux? Ulcer?	
Heart surgery?		Immunological disease?	
Artificial heart valves?		Sjogrens Disease?	
Pacemaker?		Fibromyalgia?	
Indwelling defibrillator?		Other autoimmune disease (lupus. Pemphilus)?	
Artificial joints?		Arthritis or other joint disorders?	
History of Organ Transplant?		Diabetes? Type: Controlled? Y N	
High blood pressure? BP: /		Headaches?	
Stroke?		Depression: Diagnosed?	
Bleeding problem?		Other Psychiatric Disorders?	
Hemophilia?		Neurologic Disease?	
Anemia?		Convulsions?	
Leukemia?		Epilepsy/ seizures?	
Lung Disease?		Cerebral Palsy?	
Emphysema?		Fainting/ Dizziness?	
Shortness of Breath?		Venereal Disease?	
Glaucoma?		AIDS/ HIV positive?	
Thyroid Disease?		Alcohol or chemical dependency?	
		Hepatitis?	

Have you ever had a reaction to novacaine or nitrous oxide? Yes No

Patient Signature:_____ Date:_____