MEDICAL HISTORY

Name_____ Birth Date_____ Age _____

Whom May We Notify In Case Of An Emergency? _____

Relationship to you _____ Phone_____

Name of Physician _____ Phone_____

Clinic or Facility Name _____

Check Appropriate Box

Yes ☐ No ☐ Any change in your health in the last year?

Yes ☐ No ☐ Are you currently under the care of a physician? If yes, describe your treatment _____

_____

Yes ☐ No ☐ Have you had any medical treatment or physician visit of any kind in the last year? _____

If yes, describe _____

Yes ☐ No ☐ Have you ever had any surgical operation of any kind? If yes, describe _____

_____

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR ANY OF THE FOLLOWING:

Check Appropriate Boxes

Yes	No		Yes	No	
☐	☐	Arthritis	☐	☐	Hydrocephalus
☐	☐	Rheumatic Fever	☐	☐	Anorexia, Bulimia
☐	☐	Heart Problems	☐	☐	Heart Murmur
☐	☐	High Blood Pressure	☐	☐	Thyroid Condition
☐	☐	Low Blood Pressure	☐	☐	Veneral Disease, Herpes II
☐	☐	Anemia, Sickle Cell Disease	☐	☐	Acquired Immune Deficiency Syndrome
☐	☐	Epilepsy, Seizures	☐	☐	Pacemaker type _____
☐	☐	Fainting Spells	☐	☐	Hip or Joint Replacement
☐	☐	Diabetes	☐	☐	Allergy _____
☐	☐	Hepatitis	☐	☐	Radiation or Chemical Therapy
☐	☐	Ulcers	☐	☐	Ear Infections
☐	☐	Kidney Disorder	☐	☐	Chronic Sinus
☐	☐	Tuberculosis	☐	☐	Asthma
☐	☐	Enzyme Deficiency (i.e.) G6PD	☐	☐	Hemophilia, Bleeding or Blood Disorder

☐ ☐ Tested positively as an AIDS virus carrier or have an AIDS related virus._____

☐ ☐ Do you have or have you had any other medical condition not mentioned above?

If yes, please explain _____

Yes ☐ No ☐ Are you pregnant? Anticipated delivery date _____

Yes ☐ No ☐ Do you smoke? How many packs per day? _____

Yes ☐ No ☐ Are you currently taking any prescription or non-prescription drugs of any kind (Example: aspirin, cough syrup, nasal spray, birth control, hormone, diet)? If yes, what? _____

_____

Yes ☐ No ☐ **HAVE YOU EVER HAD AN ALLERGIC REACTION OR BEEN TOLD NOT TO TAKE ANY MEDICATION?**

If yes, describe _____

I certify this medical information to be true and correct to the best of my knowledge.

Signature _____ Date_____

PATIENT OR GUARDIAN OF MINOR

Signature of Examining Dentist_____

I certify the above to be true and correct to the best of my knowledge.

Signature ______________________________ Date ______________
PATIENT OR GUARDIAN OF MINOR

Signature of Examining Dentist ______________________________

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OFFICE USE BELOW THIS LINE

Yes ☐ No ☐ VERIFIED WITH PHYSICIAN

Yes ☐ No ☐ PREMED

Pharmacist Name ______________________________

Pharmacist # ______________________________

SUBSTITUTE GENERIC