Medical History

Patient Name: .... Date of Birth: ....

G.P's Name: .... Date: ....

HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
1. Do you have any allergies	☐	☐
Please state:		
2. Heart problems	☐	☐
Please state:		
3. Rheumatic fever	☐	☐
4. High blood pressure	☐	☐
5. Stroke	☐	☐
6. Blood disorders or prolonged bleeding	☐	☐
7. Lung Disease	☐	☐
8. Asthma	☐	☐
9. Sinus problems	☐	☐
10. Kidney disease	☐	☐
11. Liver disease	☐	☐
12. Hormone deficiency, (ie, thyroid)	☐	☐
Please state:		
13. Diabetes	☐	☐
14. Digestive disorders	☐	☐

	YES	NO
15. Arthritis	☐	☐
16. Glaucoma	☐	☐
17. Osteoporosis (taking bisphosphonates)	☐	☐
18. Epilepsy, convulsions (seizures)	☐	☐
19. Neurological problems	☐	☐
Please state:		
20. Cold sores	☐	☐
21. Hay fever	☐	☐
22. Hepatitis (type ....)	☐	☐
23. Tumor, abnormal growth	☐	☐
Please state:		
24. Radiation therapy	☐	☐
25. Chemotherapy	☐	☐
26. Psychiatric treatment	☐	☐

ARE YOU:

	YES	NO
27. Presently being treated for any illness	☐	☐
Please state:		
28. Pregnant	☐	☐
29. A smoker (average per week ....)	☐	☐
30. I drink .... (units of alcohol per week)	☐	☐

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment.

....

....

List any medications, supplements including birth control.

Drug	Purpose	Drug	Purpose
....	....	....	....
....	....	....	....
....	....	....	....

Ask for an additional sheet if you are taking more than six medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES TO YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature: .... Date: ....

Dentist's Signature: .... Date: ....

Changes to Medical History

61 DENTAL

Amendments	Patient Signature	Dentist	Date