Penniall
family dental

MEDICAL HISTORY

Patient Name_____Patient DOB_____

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If so, for what?_____
   Physician's Name_____
   Address_____
2. Are you taking or have you taken any medication or drugs in the past two years? Yes No
   If yes, please list name and dosage._____
3. Are you aware of having an allergic, or adverse, reaction to any medication or substance? Yes No
   If yes, please list.
4. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)……..	Yes No	Asthma……..	Yes No
Chest Pain……	Yes No	Latex Sensitivity……	Yes No
Congenital Heart Disease…….....	Yes No	Radiation Therapy……	Yes No
Heart Murmur……..	Yes No	Chemotherapy…….....	Yes No
Mitral Valve Prolapse……..	Yes No	Hepatitis A or B……	Yes No
Artificial Heart Valve……...	Yes No	A.I.D.S…….	Yes No
Stroke……..	Yes No	H.I.V Positive…….....	Yes No
Artificial Joints…….....	Yes No	Sickle Cell Disease……	Yes No
Diabetes…….....	Yes No	Epilepsy or Seizures…….....	Yes No
Tuberculosis…….....	Yes No	Fainting or Dizzy Spells……	Yes No
High Blood Pressure…….....	Yes No		

5. Do you have or have you had any disease, problem or condition not listed? Yes No
   If yes, please list_____

6. **Women** Are you:

Pregnant…….	Yes, _____Months	No
Nursing……..	Yes	No
Taking birth control Pills…	Yes	No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature_____Date_____