MEDICAL HISTORY

Name _____ Date of Birth _____

1. Have you seen a medical doctor or been a patient in the hospital within the past two years? ☐ Yes ☐ No

If yes, for what problem? _____

2. Date of last complete physical examination _____ Kaiser Number: _____

3. Medical Doctor: Name: _____ Specialty _____ Phone # _____

Name: _____ Specialty _____ Phone # _____

4. Do you have now, or have you had in the past?:

	YES	NO		YES	NO		YES	NO
HEART ATTACK, DATE _____			ASTHMA			FAINTING OR DIZZY SPELLS		
HEART DISEASE OR FAILURE			TUBERCULOSIS (TB) / + SKIN TEST			PSYCHIATRIC TREATMENT		
ANGINA PECTORIS (CHEST PAIN)			ALLERGIES OR HIVES			CANCER OR TUMOR		
CONGENITAL HEART PROBLEM			SINUS TROUBLE			RADIATION OR CHEMOTHERAPY		
HEART OR ORGAN TRANSPLANT			DIABETES/HIGH BLOOD SUGAR			GLAUCOMA		
ENDOCARDITIS			THYROID PROBLEMS			ACID REFLUX/HEARTBURN/GERD		
BYPASS SURGERY/STENT			PINS/IMPLANTS/JOINT REPLACEMENT			ULCER (STOMACH OR INTESTINAL)		
HEART PACEMAKER / DEFIBRILLATOR			CORTISONE MEDICATION			AIDS, ARC OR HIV ANTIBODY +		
ARTIFICIAL HEART VALVE			ARTHRITIS			AUTOIMMUNE DISEASE		
HIGH BLOOD PRESSURE			BACK OR NECK PAIN			NEUROMUSCULAR DISEASE		
ANEMIA/OTHER BLOOD DISORDER			HERPES/COLD SORES/FEVER BLISTERS			KIDNEY/BLADDER TROUBLE		
EXCESSIVE BLEEDING			HEPATITIS/LIVER DISEASE			FOSAMAX/ACTONEL/BONIVA/ZOMETA		
STROKE, DATE_____			YELLOW JAUNDICE			OTHER BIPHOSPHONATES		
EMPHYSEMA			DRUG/ALCOHOL ADDICTION			OSTEOPOROSIS/OSTEOPENIA		
SHORTNESS OF BREATH			EPILEPSY OR SEIZURES			SURGERY		

5. Are you taking any medicines, drugs or pills of any kind? ☐ Yes ☐ No

Please list: _____ _____ _____

_____ _____ _____

6. Are you allergic to any drugs, medicines, latex or sulfites? ☐ Yes ☐ No

Name of substance: _____ Reaction: _____

_____ _____

7. Do you smoke or use smokeless tobacco? ☐ Yes ☐ No How much? _____

8. Do you have a disease, condition, or problem not listed above? ☐ Yes ☐ No List: _____

9. WOMEN: Are you pregnant? ☐ Yes ☐ No

Do you anticipate becoming pregnant? ☐ Yes ☐ No

Do you take birth control pills? ☐ Yes ☐ No

Date	B.P.	Initials

I have answered the above questions completely and accurately. I will inform my dentist of any change in my health or medicines at my next appointment.

_____ _____ _____

Signature of Patient, Parent or Guardian | Date | Reviewed By

Date	Change	Patient Initials	Staff Initials