gradelessdental

MEDICAL HISTORY

Patient Name: _____

1. Physician's Name _____ Phone: _____

Have you had any medical care within the past two years? ..... ☐ Yes No ☐

Describe _____

2. Have you taken any medication or drugs during the past two years? ..... ☐ Yes No ☐

If yes, please list name and dosage: _____

3. Are you currently taking any medication, drugs, pills, or herbal remedies, including regular dosages of aspirin? ..... ☐ Yes No ☐

If yes, please list name and dosage: _____

4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... ☐ Yes No ☐

If yes, please list name and dosage: _____

5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... ☐ Yes No ☐

If yes, please specify _____

6. Have you been a patient in the hospital during the past five years? ..... ☐ Yes No ☐

7. 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 ☐	Ulcers	☐ Yes	No ☐	Hepatitis A B C (circle)	☐ Yes	No ☐
Chest Pain	☐ Yes	No ☐	Diabetes	☐ Yes	No ☐	Venereal Disease	☐ Yes	No ☐
Congenital Heart Disease	☐ Yes	No ☐	Thyroid Problems	☐ Yes	No ☐	A.I.D.S./H.I.V. Positive	☐ Yes	No ☐
Heart Murmur	☐ Yes	No ☐	Glaucoma	☐ Yes	No ☐	Cold Sores/Fever Blisters	☐ Yes	No ☐
High/Low Blood Pressure	☐ Yes	No ☐	Contact lenses	☐ Yes	No ☐	Blood Transfusion	☐ Yes	No ☐
Mitral Valve Prolapse	☐ Yes	No ☐	Emphysema	☐ Yes	No ☐	Hemophilia	☐ Yes	No ☐
Artificial Heart Valve/Pacemaker	☐ Yes	No ☐	Chronic Cough	☐ Yes	No ☐	Sickle Cell Disease	☐ Yes	No ☐
Rheumatic Fever	☐ Yes	No ☐	Tuberculosis	☐ Yes	No ☐	Bruise Easily	☐ Yes	No ☐
Arthritis/Rheumatism	☐ Yes	No ☐	Asthma	☐ Yes	No ☐	Liver Disease/Yellow Jaundice	☐ Yes	No ☐
Cortisone Medicine	☐ Yes	No ☐	Hay Fever/Allergy/Hives	☐ Yes	No ☐	Neurological Disorders	☐ Yes	No ☐
Swollen Ankles	☐ Yes	No ☐	Latex Sensitivity	☐ Yes	No ☐	Epilepsy or Seizures	☐ Yes	No ☐
Stroke	☐ Yes	No ☐	Sinus Trouble	☐ Yes	No ☐	Fainting or Dizzy Spells	☐ Yes	No ☐
Diet (Special/Restricted)	☐ Yes	No ☐	Radiation Therapy	☐ Yes	No ☐	Neivous/Anxious	☐ Yes	No ☐
Artificial Joints (hip, knee, etc.)	☐ Yes	No ☐	Chemotherapy	☐ Yes	No ☐	Psychiatric/Psychological Care	☐ Yes	No ☐
Kidney Trouble	☐ Yes	No ☐	Tumors	☐ Yes	No ☐	Cancer	☐ Yes	No ☐

8. Have you lost or gained more than 10 pounds in the past year? ..... ☐ Yes No ☐

9. Do you have or have you had any disease, condition, or problem not listed? ..... ☐ Yes No ☐

If yes, please list: _____

10. **Women:** Are you pregnant or think you could be pregnant? ☐ Yes ____Months ☐ No **Nursing?** ☐ Yes No ☐

11. Do you use birth control prescriptions? ..... ☐ 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 _____

History Review [This section is for Gradeless Dental office use only]

Dentist Signature _____ Date _____