MEDICAL HISTORY REVIEW

Patient _____ Date _____

Birth Date _____ Sex: Male ____ Female ____

Address _____ City / State _____ Zipcode _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell # ( ) _____

Employer: _____ Dental Insurance _____

Insurance Subscriber: Self ____ Spouse ____ Parent ____ Email _____

MEDICAL HISTORY: Physician's name: _____ **Phone** _____

1. Are you taking medications at this time? _____

If yes, please list: _____

2. Are you allergic to or have you reacted adversely to any following medications:

Aspirin	___	Nitrous Oxide	___	Valium	___	Local Anesthetic	___
Darvon	___	Erythromycin	___	Scopolamine	___	Novocain or Xylocaine	___
Codeine	___	Tetracycline	___	Penicillin	___	Sleeping Pills	___
Demerol	___	Percodan	___	Other Antibiotics	___	Nembutal or Seconal	___
Latex	___	Sulfa	___				

3. Are you aware of being allergic to any other medications or substances? _____

If yes, please list: _____

4. Circle any of the following which you have had or have at present:

AIDS
Allergies
Anemia
Angina Pectoris
Artificial Joints (hips, knees)
Blood Transfusion
Bruise easily
Cancer
Rheumatic Fever
Sickle Cell Anemia
Sinus Trouble
Stroke
Thyroid Disease
Tuberculosis (TB)
Ulcers
Diabetes
Drug Addiction
Epilepsy or Seizures
Emphysema
Fainting or Dizzy Spells
Glaucoma
Hay Fever
Headaches
Chemotherapy
Cold Sores
Congenital Heart Lesions
Cortisone Medicine
Cough
Cosmetic Surgery
HIV Positive
Kidney Disease
Leukemia
Liver Disease
Nervousness
Pain in Jaw Joints
Psychiatric Treatment
Heart Disease or Attack
Heart Failure
Heart Murmur
Heart Pacemaker
Heart Surgery
Hemophilia
High Blood Pressure
Radiation Therapy
GI Problems
Osteoporosis
Hepatitis

Any other condition not listed: _____

WOMEN ONLY: Are you pregnant? Yes __ No __ If yes, what month _____

Are you taking birth control pills? Yes __ No __

_____ _____

Patient Signature Date