CURTISS DENTISTRY

MEDICAL HISTORY

Patient Name ______________________________ Date ____/____/________

Have you been under the care of a medical doctor during the last two years? ❑Yes ❑No

If so, for what reason(s)? ______________________________

Physician's Name ______________________________ Phone ______________________________

City______________________________ State______________ Zip______________

Have you been a patient in the hospital during the past five years? ______________________________

Are you currently taking any medications or drugs, including regular doses of aspirin or over the counter herbal medicines?_____ If so, please list name and dosage______________________________

____

Have you ever taken any prescription drugs for weight loss, including Fen-Phen, Podimen, or Redux? ______

If so, did you have a medical exam for heart issues? ❑Yes ❑No

Have you ever had an allergic reaction or adverse reaction to any medication or substance? ❑Yes ❑No

If so, please list ______________________________

Indicate which of the following you have had, or have at present. (Please check all that apply)

- ❑Heart disease, surgery, or attack
- ❑Chest pain
- ❑Congenital heart disease
- ❑ Heart murmur
- ❑ High blood pressure
- ❑Mitral valve prolapse
- ❑Heart pacemaker
- ❑Rheumatic fever
- ❑Arthritis / Rheumatism
- ❑Cortisone medicine
- ❑Stroke
- ❑Diet (special / restricted)
- ❑Artificial joints (hip, knee, etc)
- ❑ Kidney trouble
- ❑Ulcers
- ❑ Diabetes
- ❑Thyroid problems
- ❑Glaucoma
- ❑Contact lenses
- ❑ Emphysema
- ❑Tuberculosis
- ❑Asthma
- ❑Hay fever
- ❑Latex sensitivity
- ❑Allergies or hives
- ❑Sinus trouble
- ❑Radiation therapy
- ❑Tumors
- ❑Hepatitis ❑A ❑B ❑ C
- ❑Venereal disease
- ❑A.I.D.S.
- ❑H.I.V. positive
- ❑Cold sores / fever blisters
- ❑Blood transfusion
- ❑Hemophilia
- ❑Sickle cell disease
- ❑Liver disease
- ❑Yellow jaundice
- ❑Neurological disorders
- ❑Epilepsy or seizures
- ❑Fainting or dizzy spells
- ❑Psychiatric/Psychological care

Please list any disease, condition or problem not listed above:______________________________

Women: Are you pregnant? ❑Yes ❑No If so, _______ months. Nursing? ❑Yes ❑No

Do you use birth control medications? ❑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 dentist of any changes in my health or medications.

______________________________ ______________

Patient / Guardian Signature Date