Medical History

Chart No | | | | | | |

RESPONSE	CURRENT HEALTH STATUS
[ ] yes [ ] no	FOR WOMEN: Are you pregnant or suspect that you may be?
[ ] yes [ ] no	Do you currently have any health problems? If yes, list _____
	_____
[ ] yes [ ] no	Are you currently under a physicians care? If yes, why _____
[ ] yes [ ] no	Have you ever been hospitalized? If yes, when and why
	_____
[ ] yes [ ] no	Are you currently taking any medication or substances? If yes, list _____
	_____
[ ] yes [ ] no	Have you been treated for or told that you have heart disease?
[ ] yes [ ] no	Do you have high/low blood pressure?
[ ] yes [ ] no	Have you ever had medication treatment for a tumor or growth?
[ ] yes [ ] no	Do you have an infection? If yes, list _____
[ ] yes [ ] no	Would you like to speak privately to the doctor about any problem or concern?
[ ] yes [ ] no	Do you have any physical or mental handicaps? If yes, list _____
When was your last complete physical exam? _____	

Check all that apply

ALLERGIES					
	Aspirin		Erythromycin		Local dental anesthetic
	Barbiturates, sleeping pills, Valium		Food allergy		Penicillin
	Codeine		Latex Sensitivity		Sulfa Drugs
					Tetracycline
DISEASE / EXPOSURE					
	Anemia		Epstein-Bar Virus		Mononucleosis
	Arthritis		Glaucoma		Osteoporosis
	Asthma		Hay Fever		Rheumatic Fever
	Cancer/Tumors		Hemophilia (Bruise Easily)		Sickle Cell Trait/Disease
	Cerebral Palsy		Hepatitis A, B, or C		Skin Disease
	Chicken Pox/ Mumps/ Measles		Herpes I or II		Thyroid Disorder
	Crohn's Disease		HIV/AIDS		Tuberculosis
	Diabetes		Kidney Disease / Transplant		Venereal Disease
	Epilepsy or Seizure		Liver Disease		Yellow Jaundice
ILLNESSES AND SURGERIES					
	Adenoids		Headache		Mitral Valve Prolapse
	Artificial Heart Valve		Heart Attack		Pacemaker/ Defibrillator
	Cosmetic		Heart Surgery		Swollen Lymph Glands
	Gastric / Intestinal Disorder		Joint replacement		Tonsils
LIFESTYLE HABITS					
	Alcohol Consumption		Drug Use/Addiction		Tobacco Use / Smoking

I have answered all questions to the best of my knowledge, and I understand that the above information is necessary to provide me with safe dental care. In addition, I authorize Arundel Mills Dental Group to obtain clarification or additional information from the respective healthcare providers or agencies identified on this form in order to facilitate diagnosis and treatment. I certify that the above information is complete and accurate.

Print Patient Name _____ Patient or Parent/Guardian's Signature _____ Date _____

For Office Use Only Below This Line
DOCTOR'S NOTES

Anest.		**Med. Alert**

VITALS					
Height		BP		Pulse	
Weight		Respiration Rate		Temperature	

DATE	CURRENT MEDICAL PROBLEM	CURRENT MEDICATIONS

Doctor's Signature

Date