ALLEN VALLEY DENTAL
EXCELLENCE IN DENTISTRY

Today's Date _____

MEDICAL HISTORY (CONFIDENTIAL)

Name _____
Last First MI

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations?

☐ No ☐ Yes. If yes, describe with dates:

Have you ever had a blood transfusion?

☐ No ☐ Yes. If yes, approximate date:

Women:

Are you pregnant?	☐ No	☐ Yes
Nursing?	☐ No	☐ Yes
Taking Birth control pills?	☐ No	☐ Yes

Check if you have or have had any of the following:

☐ AIDS / HIV Positive	☐ Cortisone Treatments	☐ Hemophilia	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ Hepatitis A/ B/ other	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Jaw Pain	☐ Shortness of Breath
☐ Artificial Heart Valve	☐ Diabetes	☐ Kidney Disease	☐ Sinus Problems
☐ Artificial Joints	☐ Epilepsy	☐ Liver Disease	☐ Skin Rash
☐ Asthma	☐ Fainting	☐ Mitral Valve Prolapse	☐ Stroke
☐ Back Problems	☐ Glaucoma	☐ Nervous Problems	☐ Swelling of Feet/Ankles
☐ Blood Disease	☐ Headaches	☐ Pacemaker	☐ Thyroid Problems
☐ Cancer	☐ Heart Murmur	☐ Phen/Fen Therapy	☐ Tobacco Habit
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Circulatory Problems	describe:	☐ Radiation Treatment	☐ Ulcer
		☐ Respiratory Disease	☐ Venereal Disease

MEDICATIONS

List medications you are currently taking

_____

_____

Is there anything else we should know about your health that we have not covered on this form?

_____

_____

ALLERGIES

☐ Aspirin	☐ Sulfa	☐ Other
☐ Codeine	☐ Latex	
☐ Penicilin	☐ Local Anesthetic	

Do you have any disease, condition or problem not listed? Is so, please explain.

_____

_____

Would you like to speak to the doctor privately about any problem?

☐ Yes ☐ No

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completing this form.

Patient Signature **Date** **Doctor Signature** **Date**

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