Creekside Dentistry
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MEDICAL HISTORY FORM

Patient Name	
Physician:	Physician phone number:
Have you been under the active care of a physician for an ongoing issue over the past two years? If yes, please describe:	Y ○ N ○
Are you currently taking any medications, drugs, pills, herbal remedies, including aspirin? If yes, please list.	Y ○ N ○
Have you taken prescription medications for weight loss, such as Fen-Phen, Pondimen, or Redux?	Y ○ N ○
Have you taken prescription medications for bone density such as Fosamax, Actonel, or Boniva?	Y ○ N ○
Have you ever had an adverse or allergic reaction of any medications? If so, please list.	Y ○ N ○
Have you been admitted to the hospital in the last 5 years? For:	Y ○ N ○

Have you had or currently have any of the following:

Cardiology:			**Endocrine:**			**Immunologic:**		
Heart Condition	Y ○	N ○	Liver disease/Yellow Jaundice	Y ○	N ○	Cold sores/fever blisters	Y ○	N ○
Chest Pain	Y ○	N ○	Thyroid Problems	Y ○	N ○	Blood Transfusion	Y ○	N ○
Heart Murmur	Y ○	N ○	Glaucoma	Y ○	N ○	Hay Fever/Allergy/Hives	Y ○	N ○
High/Low Blood Pressure	Y ○	N ○	**Respiratory:**			Latex sensitivity	Y ○	N ○
Mitral Valve Prolapse	Y ○	N ○	COPD/Emphysema	Y ○	N ○	**Neurologic:**		
Artificial Heart Valve/Pacemaker	Y ○	N ○	Chronic Cough	Y ○	N ○	Neurological Disorders	Y ○	N ○
Stroke	Y ○	N ○	Tuberculosis	Y ○	N ○	Epilepsy or Dizzy spells	Y ○	N ○
Swollen Ankles/Bruise Easily	Y ○	N ○	Asthma	Y ○	N ○	Nervous/Anxious	Y ○	N ○
Rheumatic Fever	Y ○	N ○	Sinus Trouble	Y ○	N ○	Psychiatric/Psychological Care	Y ○	N ○
Hemophilia/Sickle Cell	Y ○	N ○						
Musculoskeletal:						**Neoplastic:**		
Arthritis/Rheumatism	Y ○	N ○	**Acquired Diseases:**			Tumors / cancer	Y ○	N ○
Artificial Joints	Y ○	N ○	Hepatitis A, B or C	Y ○	N ○	Radiation/Chemotherapy	Y ○	N ○
Gastro-urologic:			Venereal Disease	Y ○	N ○			
Kidney Trouble	Y ○	N ○	HIV/AIDS	Y ○	N ○	**Other:**		
Ulcers	Y ○	N ○				Diet (special or restricted)	Y ○	N ○
Diabetes	Y ○	N ○				Contact Lenses	Y ○	N ○

Have you had any diseases or conditions not listed above? Yes ○ No ○ if yes, what?_____

Have you gained or lost more than 10 pounds in the past year? Yes ○ No ○ if yes which?_____

Women: Are you pregnant or think you could be pregnant? Yes ○ No ○ if yes how far along?_____

Women: Are you nursing Yes ○ No ○ Women: Are you using birth control prescriptions? Yes ○ No ○

Anything else you would like to share?

I understand the above information is necessary to provide me with dental care in a safe and caring 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. I will notify the doctor or any change in my health or medication.

_____ _____
Patient Signature Date

Doctor's Notes: _____

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_____ _____
Doctor's signature Date