Patient Name	Medical Alert

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have , or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1. Are you under the care of a physician? .... Yes No
   If yes, for what ____________________
   Physician's Name ____________________ Phone ____________________
   Address ____________________ City ____________________ State __________ Zip __________
2. Are you taking any medication, drugs or pills now? .... Yes No
   If yes, please list name and dosage ____________________
3. Are you aware of having an allergic (or adverse reaction) to any medication or substance? .... Yes No
4. Have you been a patient in the hospital during the past five years? .... Yes No
5. Indicate which of the following you have had, or have a present. Circle "yes" or "no" to each item.

Condition			Condition			Condition		
Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious) B (Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	Bleeding Problems	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

6. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
   If yes, please list: ____________________
7. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No
8. Do you have more than 3 alcoholic drinks a day? .... Yes No
9. Do you use herbal or other non-prescription remedies? .... Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE ____________________

HISTORY REVIEW

SUMMARY BP__________ Pulse __________

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

MEDICATIONS

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

ASA

I
II
III
IV

MEDICAL HISTORY