IntegrityDental

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____ Today's Date: _____

When was your last physical exam with your primary care provider? _____

Are you under a physician's care now?	◯ Yes	◯ No
Do you have any ongoing medical conditions?	◯ Yes	◯ No
Have you ever been hospitalized or had any surgeries?	◯ Yes	◯ No
Are you taking any medications, pills, or drugs?	◯ Yes	◯ No
Do you use or have ever used tobacco products?	◯ Yes	◯ No
Do you use or have ever used controlled substances?	◯ Yes	◯ No
Have you ever received treatment for substance abuse?	◯ Yes	◯ No

If yes to any of the questions above, please explain: _____

_____

_____

_____

Women, are you:
Pregnant / Trying to get pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No

Are you allergic or sensitive to any of the following:
☐ Penicillin ☐ Sulfa drugs ☐ Narcotics / codeine ☐ Local anesthetics ☐ Latex ☐ Metals ☐ Other: _____

Do you have or have you ever had any of the following:

◯ Y ◯ N AIDS / HIV	◯ Y ◯ N Cortisone medications	◯ Y ◯ N Hemophilia	◯ Y ◯ N Radiation treatment
◯ Y ◯ N Alzheimer's Disease	◯ Y ◯ N Diabetes	◯ Y ◯ N Hepatitis A	◯ Y ◯ N Renal dialysis
◯ Y ◯ N Anaphylaxis	◯ Y ◯ N Drug addiction	◯ Y ◯ N Hepatitis B or C	◯ Y ◯ N Rheumatic fever
◯ Y ◯ N Anemia	◯ Y ◯ N Easily winded	◯ Y ◯ N High blood pressure	◯ Y ◯ N Rheumatism
◯ Y ◯ N Angina	◯ Y ◯ N Emphysema	◯ Y ◯ N High cholesterol	◯ Y ◯ N Shingles
◯ Y ◯ N Arthritis / Gout	◯ Y ◯ N Epilepsy / Seizures	◯ Y ◯ N Hives / rash	◯ Y ◯ N Sickle cell disease
◯ Y ◯ N Artificial heart valve	◯ Y ◯ N Excessive bleeding	◯ Y ◯ N Hypoglycemia	◯ Y ◯ N Sinus trouble
◯ Y ◯ N Artificial joint	◯ Y ◯ N Excessive thirst	◯ Y ◯ N Intestine disease	◯ Y ◯ N Spina bifida
◯ Y ◯ N Asthma	◯ Y ◯ N Fainting / Dizziness	◯ Y ◯ N Irregular heartbeat	◯ Y ◯ N Stomach disease
◯ Y ◯ N Blood disease	◯ Y ◯ N Frequent cough	◯ Y ◯ N Jaundice	◯ Y ◯ N Stroke
◯ Y ◯ N Blood transfusion	◯ Y ◯ N Frequent diarrhea	◯ Y ◯ N Kidney problems	◯ Y ◯ N Swelling of limbs
◯ Y ◯ N Breathing problem	◯ Y ◯ N Frequent headaches	◯ Y ◯ N Leukemia	◯ Y ◯ N Thyroid disease
◯ Y ◯ N Bruise easily	◯ Y ◯ N Genital / oral herpes	◯ Y ◯ N Liver disease	◯ Y ◯ N Tonsilitis
◯ Y ◯ N Cancer	◯ Y ◯ N Glaucoma	◯ Y ◯ N Low blood pressure	◯ Y ◯ N Tuberculosis
◯ Y ◯ N Chemotherapy	◯ Y ◯ N Hay fever	◯ Y ◯ N Lung disease	◯ Y ◯ N Tumors / growths
◯ Y ◯ N Chest pains	◯ Y ◯ N Heart attack / failure	◯ Y ◯ N Osteoperosis	◯ Y ◯ N Ulcers
◯ Y ◯ N Cold sores	◯ Y ◯ N Heart murmur	◯ Y ◯ N Pain in jaw joints	◯ Y ◯ N Venereal disease
◯ Y ◯ N Congenital heart	◯ Y ◯ N Heart pacemaker	◯ Y ◯ N Parathyroid disease	◯ Y ◯ N Head / neck injury
◯ Y ◯ N Convulsions	◯ Y ◯ N Heart disease	◯ Y ◯ N Psychiatric care	◯ Y ◯ N Other

Signature of Patient / Legal Guardian: _____

Doctor Use Only