

Schramm Dentistry

MEDICAL HISTORY

Patient Name _____

1. Are you currently under the care of a medical doctor? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone No. _____
 Address _____ City _____ State _____ Zip _____
2. Are you taking any medication, drugs or pills? 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
 If yes, please list _____
4. Have you been a patient in the hospital during the past five years? Yes No
 If yes, why? _____
5. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

Heart (surgery, disease, attack).....	Yes	No	Ulcers.....	Yes	No	Hepatitis A (infectious) B (serum).....	Yes	No
Chest pain	Yes	No	Diabetes	Yes	No	Hepatitis C	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems	Yes	No	AIDS.....	Yes	No
Heart Murmur	Yes	No	Glaucoma.....	Yes	No	HIV 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 Trouble	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 so, please list _____
7. Women: Are you: Pregnant? Yes, _____ months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient 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, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____