# MEDICAL HISTORY

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Marcin DENTAL CENTERS

**PATIENT NAME** _____

***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 receive. Thank you for answering the following questions.***

1. Have you been under the care of a medical doctor for a major illness during the past two years? ☐ Yes ☐ No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____
   City _____ State _____ Zip _____
2. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
   If yes, please explain: _____
3. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
   If yes, please list: _____
4. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medications? ☐ Yes ☐ No If yes, please list name and dosage or attach list: _____
   _____
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No
   If yes, please indicate: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other _____
6. **Women:** Are you Pregnant/May be pregnant - if indicated, how many months ____ ☐ Nursing ☐ Taking oral contraceptives

## INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD, OR HAVE AT PRESENT WITH AN X

☐ Heart (Surgery, Disease, Attack)
☐ Mitral Valve Prolapse
☐ Heart Pacemaker
☐ Rheumatic Fever
☐ Stroke
☐ Artificial Joints (hip, knee, etc.)
☐ Latex Sensitivity
☐ Congenital Heart Disease
☐ Chest Pain
☐ Arthritis Rheumatism
☐ Cortisone Medicine
☐ Swollen Ankles
☐ High Blood Pressure
☐ Diet (Special Restricted)
☐ Heart Murmur
☐ Kidney Trouble
☐ Ulcers
☐ Diabetes
☐ Thyroid Problems
☐ Emphysema
☐ Chronic Cough
☐ Tuberculosis
☐ Asthma
☐ Artificial Heart Valve
☐ Allergies or Hives
☐ Sinus Trouble
☐ Radiation Therapy
☐ Chemotherapy
☐ Tumors
☐ Hepatitis A B C *(Circle One)*
☐ A.I.D.S.
☐ H.I.V. Positive
☐ Cold Sores/Fever Blisters
☐ Blood Transfusion
☐ Hemophilia
☐ Sickle Cell Disease
☐ Bruise Easily
☐ Liver Disease
☐ Neurological Disorders
☐ Epilepsy or Seizures
☐ Fainting or Dizzy Spells
☐ Nervous / Anxious
☐ Psychiatric / Psychological Care
☐ Drug Addiction

***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.***

**Patient / Guardian Signature** _____ **Date** _____

**History Review**

Clinician Initials _____ Date _____ Dr. Signature _____
Clinician Initials _____ Date _____ Notes/Updates _____
Clinician Initials _____ Date _____ Notes/Updates _____