QE INC.

MEDICAL HISTORY

Patient Name_____ Nickname_____ Age_____

Name of Physician _____

Date of last physical examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

CHECK IF YOU HAVE, OR EVER HAD THE FOLLOWING:

1. hospitalization for illness or injury ❑
2. allergic reation to
   - ❑ aspirin
   - ❑ penicillin
   - ❑ erythromycin
   - ❑ codeine
   - ❑ local anesthetic
   - ❑ fluoride
   - ❑ metals (gold, stainless steel)
   - ❑ any other medications _____
3. heart problems ❑
4. heart murmur ❑
5. rheumatic fever ❑
6. scarlet fever ❑
7. high blood pressure ❑
8. low blood pressure ❑
9. a stroke ❑
10. artificial prosthesis (i.e., heart valve or joints) ❑
11. anemia or other blood disorder ❑
12. prolonged bleeding due to a slight cut ❑
13. emphysema ❑
14. tuberculosis ❑
15. asthma ❑
16. sinus problems ❑
17. diabetes ❑
18. kidney disease ❑
19. liver disease ❑
20. jaundice ❑
21. thyroid or parathyroid disease ❑
22. stomach or duodenal ulcer ❑
23. arthritis ❑
24. glaucoma ❑
25. contact lenses ❑
26. head or neck injuries ❑
27. epilepsy, convulsions (seizures) ❑
28. viral infections and cold sores ❑
29. any lumps or swelling in the mouth ❑
30. hives, skin rash, hay fever ❑
31. venereal disease ❑
32. hepatitis (type ___) ❑
33. aids (acquired immune deficiency syndrome) ❑
34. tumor, abnormal growth ❑
35. radiation therapy ❑
36. chemotherapy ❑
37. emotional problems ❑
38. psychiatric treatment ❑
39. antidepressant medication ❑
40. alcohol/drug dependency ❑
41. presently treating for any illness ❑
42. aware of a change in your general health ❑
43. often exhausted or fatigued ❑
44. subject to frequent headaches ❑
45. heavy smoker (1pack or more/day) ❑
46. generally a nervous person ❑
47. often unhappy or depressed ❑
48. FEMALE – taking birth control pills ❑
49 FEMALE – pregnant ❑
50. MALE – Prostate disorders ❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

_____

List any medications taken within the last two years _____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature_____ Date_____

Dentist Remarks_____

_____ Rev: _____

OVER