Medical History

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Name:

Date:

Please answer the following questions as accurately as possible. This information is necessary in providing the best service to you and, of course, is confidential. Please let us know of any changes to information pertaining to your health, and we will update this form. Thank you! ***Mathew B. Dorsch,*** *DDS*

1. **Have you been under the care of a medical doctor within the past two years?** YES NO
   If yes, for what? *When?*
   Physician's name: *Phone:*
   Address: *City:* *Zip:*
2. **Have you taken any medications or drugs within the past two years?** YES NO
3. **Are you taking any medications, drugs or pills now, including aspirin and/or birth control pills?** YES NO
   If yes, please list the name and dosage:
4. **Have you ever taken medications for osteoporosis (Fosamax, Boniva, Actonel)?** YES NO
5. **Have you ever taken prescription medications for weight loss (diet pills)?** YES NO
6. **Are you aware of having an allergic (or adverse) reaction to any medication or substance, including metal?** YES NO
   If yes, what are you allergic to?
7. **Have you been a patient in the hospital during the past five years?** YES NO
8. **Do you use pillows to help position yourself in order to sleep?** YES NO
9. **Have you gained or lost more than ten pounds this year?** YES NO
10. **Women:** *Are you Pregnant?* YES NO *Nursing?* YES NO *Taking birth control pills?* YES NO
11. **Indicate which of the following you have had or are having at present:**

Heart Problems:			Emphysema	YES	NO	Sickle cell anemia	YES	NO
✔ Heart Surgery	YES	NO	Chronic cough	YES	NO	IV drug use	YES	NO
✔ Heart Murmur	YES	NO	Tuberculosis	YES	NO	Drug addiction	YES	NO
✔ Heart Attack	YES	NO	Asthma	YES	NO	Blood transfusion	YES	NO
✔ Heart MVP	YES	NO	Hay fever	YES	NO	Liver disease	YES	NO
✔ Rheumatic fever	YES	NO	Latex sensitivity	YES	NO	Yellow jaundice	YES	NO
✔ Heart Disease	YES	NO	Sinus trouble	YES	NO	Neurologic disorder	YES	NO
✔ Pacemaker	YES	NO	Tumors	YES	NO	Seizure disorder	YES	NO
✔ Artificial heart valve	YES	NO	Leukemia	YES	NO	Fainting/dizziness	YES	NO
✔ Heart failure	YES	NO	Cancer	YES	NO	Epilepsy	YES	NO
✔ Heart Angina	YES	NO	Chemotherapy	YES	NO	Nervous anxiety	YES	NO
✔ Chest pain	YES	NO	Radiation therapy	YES	NO	Psychiatric care	YES	NO
High blood pressure	YES	NO	Hepatitis (A,B,C,D)	YES	NO	Restricted diet	YES	NO
Stroke	YES	NO	Herpes/Cold sores	YES	NO	Cortisone medicine	YES	NO
Diabetes	YES	NO	Venereal disease	YES	NO	Retinal surgery	YES	NO
Thyroid problems	YES	NO	HIV / AIDS	YES	NO	Swollen ankles	YES	NO
Glaucoma	YES	NO	Ulcers	YES	NO	Kidney troubles	YES	NO
Anemia	YES	NO	Hives	YES	NO	Artificial joints	YES	NO
Hemophilia	YES	NO	Allergies	YES	NO	Arthritis	YES	NO
Bruise easily	YES	NO	Tobacco use	YES	NO			

12. **Do you have, or have you had any disease, condition or problem not listed?** YES NO
    If so please list it here:

I understand the above information is necessary to provide me with dental care in a safe and effective 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 changes in my health or medication.

Patient/Guardian signature: **Date:**

FOR OFFICE STAFF USE ONLY:

Initial exam date:	Comments:	
Date:	Changes:	Initials:
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