# MEDICAL HISTORY

Hymas Family Dental

Patient Name _____

Birthdate _____

Physician's Name _____ Date of Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Have you been under the care of a medical doctor during the past two years? **Y N** If yes, please explain. _____

_____

Do you take, or have you taken, Phe-n-Fen or Redux? **Y N**

Have you ever taken Fosamax, Boniva., Acton el or any other medications containing bisphosphonates? **Y N**

**Do you use controlled substances? Y N**

Please circle yes or no to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Y N | Diabetes | Y N | Hepatitis B or C | Y N | Rheumatic Fever | Y N |
| Alzheimer's Disease | Y N | Drug Addiction | Y N | Herpes | Y N | Rheumatism | Y N |
| Anaphylaxis | Y N | Easily Winded | Y N | High Blood Pressure | Y N | Scarlet Fever | Y N |
| Anemia | Y N | Emphysema | Y N | High Cholesterol | Y N | Shingles | Y N |
| Angina | Y N | Epilepsy or Seizures | Y N | Hives or Rash | Y N | Sickle Cell Disease | Y N |
| Arthritis/Gout | Y N | Excessive Bleeding | Y N | Hypoglycemia | Y N | Sinus Trouble | Y N |
| Artificial Heart Valve | Y N | Excessive Thirst | Y N | Irregular Heartbeat | Y N | Spina Bifida | Y N |
| Artificial Joint | Y N | Fainting Spells/Dizziness | Y N | Kidney Problems | Y N | Stomach/Intestinal Disease | Y N |
| Asthma | Y N | Frequent Cough | Y N | Leukemia | Y N | Stroke | Y N |
| Blood Disease | Y N | Frequent Diarrhea | Y N | Liver Disease | Y N | Swelling of Limbs | Y N |
| Blood Transfusion | Y N | Frequent Headaches | Y N | Low Blood Pressure | Y N | Thyroid Disease | Y N |
| Breathing Problems | Y N | Genital Herpes | Y N | Lung Disease | Y N | Tonsillitis | Y N |
| Bruise Easily | Y N | Glaucoma | Y N | Mitral Valve Prolapse | Y N | Tuberculosis | Y N |
| Cancer | Y N | Hay Fever | Y N | Osteoporosis | Y N | Tumors or Growths | Y N |
| Chemotherapy | Y N | Heart Attack/Failure | Y N | Pain in Jaw Joints | Y N | Ulcers | Y N |
| Chest Pains | Y N | Heart Murmur | Y N | Parathyroid Disease | Y N | Venereal Disease | Y N |
| Cold Sores/Fever Blisters | Y N | Heart Pacemaker | Y N | Psychiatric Care | Y N | Yellow Jaundice | Y N |
| Congenital Heart Disorder | Y N | Heart Trouble/Disease | Y N | Radiation Treatments | Y N | | |
| Convulsions | Y N | Hemophilia | Y N | Recent Weight Loss | Y N | | |
| Cortisone Medicine | Y N | Hepatitis A | Y N | Renal Dialysis | Y N | | |

**Allergies** [ ] NONE [ ] Amoxicillin [ ] Aspirin [ ] Barbiturates [ ] Codeine [ ] Epinephrine [ ] Erythromycin [ ] Keflex
[ ] Iodine [ ] Latex [ ] Lortab [ ] Morphine [ ] Penicillin [ ] Sulfa [ ] Tetracycline [ ] Other _____

List medications currently taking (name and dosage) _____

_____

Do you have or have you had any disease, condition or problem not listed above? Y N

If yes, please explain _____

**Do you need to take any antibiotics (pre-medicate) before any dental appointment?** Y N

Have you been in the hospital or had a serious illness within the past five years? Y N

If yes, Please explain _____

Women: Are you pregnant? Y N Due date_____ Are you nursing? Y N Do you take Birth Control Pills? Y N

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 / Parent / Guardian Signature X** _____ Date _____

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