

**VALLEY BROOK FAMILY DENTAL**  
**Patient Medical History**

**MEDICAL HISTORY**

**PATIENT NAME:** \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Are you in good health? Yes \_\_\_ No \_\_\_

Is there any possibility of pregnancy? No \_\_\_ Yes \_\_\_\_\_. If so, when is your due date: \_\_\_\_\_.

Have you been hospitalized or had a serious illness within the past 5 years? . . . . . Yes \_\_\_ No \_\_\_

If so, please explain \_\_\_\_\_

**If you have or have ever had any of the following medical conditions, please check.**

- |   |                                    |                                 |
|---|------------------------------------|---------------------------------|
| Heart murmur..... ___                   | Hay fever. .... ___                | Emphysema. .... ___             |
| Mitral or Aortic Valve Prolapse . . ___ | Hives or rash. .... ___            | Bronchitis. .... ___            |
| Heart Attack, Bypass or Stents . . ___  | Fainting spells. .... ___          | Persistent cough. .... ___      |
| Irregular heart beat . . . . . ___      | Seizures . . . . . ___             | Venereal disease . . . . . ___  |
| High blood pressure . . . . . ___       | Diabetes. .... ___                 | HIV or ARC . . . . . ___        |
| Arteriosclerosis . . . . . ___          | Hepatitis A, B, or C . . . . . ___ | Artificial joints . . . . . ___ |
| Stroke . . . . . ___                    | Liver disease . . . . . ___        | Blood disorders . . . . . ___   |
| Angina . . . . . ___                    | Arthritis. .... ___                | Tumors or growths . . . . . ___ |
| Rheumatic fever . . . . . ___           | Ankles swell . . . . . ___         | Kidney trouble . . . . . ___    |
| Rheumatic heart disease . . . . . ___   | Asthma . . . . . ___               | Tuberculosis . . . . . ___      |
| Chest pain with exertion . . . . . ___  | Rheumatoid arthritis . . . . . ___ | Stomach ulcers. . . . . ___     |
| Shortness of breath . . . . . ___       | Cancer irradiation . . . . . ___   | Other? . . . . . ___            |
| Other communicable diseases: . . . . .  |                                    |                                 |

Have you ever had a blood transfusion? \_\_\_Yes \_\_\_No Do you have any allergies? \_\_\_ Yes \_\_\_No

Please List: \_\_\_\_\_

**Have you ever been told that you are allergic to:**

Aspirin \_\_\_ Tylenol \_\_\_ Novocain \_\_\_ Penicillin \_\_\_ Tetracycline \_\_\_ Other antibiotics: \_\_\_\_\_  
Barbiturates \_\_\_ Codeine \_\_\_ Other Narcotics or Sedatives: \_\_\_\_\_

**Are you currently taking any over the counter or prescription medications? Yes \_\_\_ No \_\_\_**

Please list: \_\_\_\_\_

**Have you taken bisphosphonates drugs like Flosamax for osteoporosis or cancer treatment at any time during the last 10 years? Yes \_\_\_ No \_\_\_.** If yes please explain: \_\_\_\_\_

**DENTAL HISTORY**

Purpose of this visit: \_\_\_\_\_ Date of last dental xrays: \_\_\_\_\_

Name of last dentist \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

Have you ever had a bad dental experience? . . . . . Yes \_\_\_ No \_\_\_ If yes please explain below:

Please Explain: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Patient or Legal Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Doctor)