Miller and Associates
FAMILY DENTISTRY

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MEDICAL HISTORY

Patient's Name: _____ Birthday: _____ SSN: _____ Today's Date: _____
What is your general state of health? Excellent ____ Good ____ Fair ____ Poor ____

PHYSICIAN'S INFORMATION

Physician's Name: _____
Physician's Address: _____ **Office Phone #**: _____
Have you been under a physician's care during the last two years? _____
Have you been treated in a hospital in the past three years? _____
Have you had major surgery? _____ What/When? _____
Do you or have you been told to **PRE-MEDICATE** before appointments? _____
IF FEMALE: Are you pregnant? _____ Due Date _____ Nursing? _____ On birth control? _____

Do you have or have you had any of the following? PLEASE MARK YES OR NO (ON ALL)

Yes	No	AIDS/HIV+	Yes	No	Implants
Yes	No	Arthritis	Yes	No	Irregular Heart Beat
Yes	No	Artificial Heart Valves	Yes	No	Kidney Problems
Yes	No	Artificial Joints	Yes	No	Liver Disease
Yes	No	Asthma	Yes	No	Mental illness
Yes	No	Bruise/Bleed Easily	Yes	No	Mitral Valve Prolapsed
Yes	No	Cancer	Yes	No	Nervousness/Anxious
Yes	No	Chemotherapy	Yes	No	Organ Transplant
Yes	No	Chest Pain/Angina	Yes	No	Pacemaker
Yes	No	Congenital Heart Lesions	Yes	No	Persistent Cough
Yes	No	Diabetes	Yes	No	Pneumonia
Yes	No	Dry Mouth	Yes	No	Radiation Therapy
Yes	No	Emphysema/ Bronchitis	Yes	No	Rheumatic Fever
Yes	No	Epilepsy/Seizures	Yes	No	Sickle Cell Anemia
Yes	No	Fainting/Dizziness	Yes	No	Sinus Problems
Yes	No	Fibromyalgia	Yes	No	Stroke
Yes	No	Heart Problem/Murmur	Yes	No	Thyroid Disease
Yes	No	Heart Surgery	Yes	No	Tobacco Use
Yes	No	Hepatitis A, B, C	Yes	No	Tuberculosis/ PPD+
Yes	No	High Blood Pressure	Yes	No	Venereal Disease

MEDICATIONS

Please list **ALL** medications you are taking, including over the counter drugs and herbs.

Are you in a pain management program? Yes No If so, what medication(s) are you taking, including any ADD, ADHD, or sleeping aids _____

Have you had a mastectomy? Yes No

Do you have any drug allergies? PLEASE MARK YES OR NO (ON ALL)

Yes	No	Antibiotics (Erythromycin/Tetracycline/Penicillin/Flagyl)	Yes	No	Dental Anesthetics
Yes	No	Aspirin (Ibuprofen, Acetaminophen)	Yes	No	Latex
Yes	No	Codeine	Yes	No	Sulfa

Any other allergies not listed: _____