OAK VALLEY DENTAL ASSOCIATES

MEDICAL HISTORY

Physician: _____ Office Phone: _____ Date of last exam: _____

1. Are you under medical treatment now? ☐ Yes ☐ No Reason: _____

2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No
   If yes, please explain: _____

3. Are you taking any medication, drugs or pills now (including regular doses of aspirin, vitamins, herbals, and homeopathic meds)? ☐Yes ☐No If yes, please list name, dosage and reason for taking: _____

4. Have you ever taken prescription medication for weight loss (e.g., Fenphen, Redux)? ☐ Yes ☐ No

5. Are you allergic to or have had an adverse reaction to any of the following? Aspirin ☐ Yes ☐ No
   Local anesthetic (e.g., novocaine) ☐ Yes ☐ No Penicillin or other antibiotics ☐ Yes ☐ No
   Sulfa drugs ☐Yes ☐No Latex ☐Yes ☐No

6. Indicate which of the following you have had or currently have. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Hepatitis (type:_____)	Yes	No
Chest Pain	Yes	No	Cancer	Yes	No
Heart Murmur	Yes	No	Radiation Therapy	Yes	No
High Blood Pressure	Yes	No	Venereal Disease (STD)	Yes	No
Low Blood Pressure	Yes	No	A.I.D.S/H.I.V. positive	Yes	No
Mitral Valve Prolapse	Yes	No	Epilepsy or Seizures	Yes	No
Heart Pacemaker	Yes	No	Fainting or Dizzy Spells	Yes	No
Rheumatic Fever	Yes	No	Anemia	Yes	No
Arthritis/Rheumatism	Yes	No	Frequent Heartburn/Reflux/Gerd	Yes	No
Swollen Ankles	Yes	No	Recent Weight Loss	Yes	No
Stroke	Yes	No	Ulcers	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Diabetes	Yes	No
Kidney Trouble	Yes	No	Emphysema	Yes	No
Thyroid Problems	Yes	No	Tuberculosis	Yes	No
Glaucoma	Yes	No	Asthma	Yes	No
Contact Lenses	Yes	No	Hay Fever	Yes	No

7. WOMEN: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No
   Taking Birth Control Pills? ☐ Yes ☐ No Experiencing Menopausal changes? ☐ Yes ☐ No

8. If you have any disease, condition, or problem not listed above, please explain: _____

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

X_____ Date: _____
Signature of patient (or parent if minor)

History Review

Please complete other side of form