Dr. Judy Tiffany
Monarch View Dental
Patient Medical History

PATIENT NAME: _____ Date: _____

1. Physician's Name _____ ___ **Phone:** _____
Have you had any medical care within the past two years? Yes No
Describe: _____

2. Have you taken any drugs or medication during the past two years? Yes No
If yes please list name or dosage _____

3. Are you currently taking any medications, drugs, pills, or herbal remedies, including regular dosages of aspirin? Yes No
If yes please list name or dosage _____

4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other bisphosphonates? Yes No
If yes please list name or dosage _____

5. Are you aware of any allergic (or adverse) reactions to any substance or medication? Yes No
If yes, please specify_____

6. Have you been a patient in the hospital during the past five years? Yes No
If yes, please specify_____

7. Indicate which of the following you have had, or have at present. Circle "yes' or "no" to each item.

Heart (Surgery, Disease, Attack)	YES	NO	Ulcers	YES	NO
Chest Pain	YES	NO	Diabetes	YES	NO
Congenital Heart Disease	YES	NO	Thyroid Problems	YES	NO
Heart Murmur	YES	NO	Glaucoma	YES	NO
High/Low Blood Pressure	YES	NO	Contact Lenses	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO
Artificial Heart Valve/Pacemaker	YES	NO	Chronic Cough	YES	NO
Rheumatic Fever	YES	NO	Tuberculosis	YES	NO
Arthritis/Rheumatism	YES	NO	Asthma	YES	NO
Cortisone Medicine	YES	NO	Hay Fever/Allergy/Hives	YES	NO
Swollen Ankles	YES	NO	Latex Sensitivity	YES	NO
Stoke	YES	NO	Sinus Trouble	YES	NO
Diet(Special/Restrictions)	YES	NO	Radiation Therapy	YES	NO
Artificial Joints(hip, knee, etc.)	YES	NO	Chemotherapy	YES	NO
Kidney Trouble	YES	NO	Tumors	YES	NO

Patient : _____

MEDICAL HISTORY CONTINUED

Hepatitis A B C	YES	NO	Venereal Disease	YES	NO
AIDS/HIV Positive	YES	NO	Cold Sores/Fever Blisters	YES	NO
Blood Transfusion	YES	NO	Hemophilia	YES	NO
Sickle Cell Disease	YES	NO	Bruise Easily	YES	NO
Liver Disease/Yellow Jaundice	YES	NO	Neurological Disorders	YES	NO
Epilepsy or Seizures	YES	NO	Fainting or Dizzy Spells	YES	NO
Nervous/Anxious	YES	NO	Cancer	YES	NO
Psychiatric/Psychological Care	YES	NO			

8. Have you lost or gained more than 10 pounds in the past year? **YES NO**
If yes, please specify_____

9. Do you have any other disease, condition, or problem not listed? **YES NO**
If yes, please list:_____

10. WOMEN: Are you pregnant or think you could be pregnant? **YES NO**
If yes, please specify_____ **Nursing?** **YES NO**

11. Do you use birth control prescriptions? **YES NO**

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the 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 any change in my health or medications.

Patient/Guardian Signature _____Date _____

History Review to be completed by Provider:

_____

_____

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Dentist Signature : _____ **Date:** _____