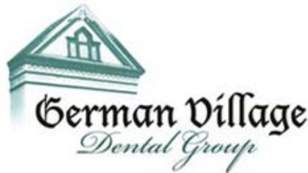

MEDICAL HISTORY

PATIENT NAME ______________________________ **BIRTH DATE** ______________________

Primary Care Physician's Name ______________________________
Primary Care Physician's Phone: ______________________________
Date of Last Medical Exam: ______________________________

Are you currently under the care of a physician for a specific condition?	☐ YES	☐ NO
Have you been hospitalized in the past 5 years for a serious illness or operation?	☐ YES	☐ NO
Do you use tobacco (smoking or chewing)?	☐ YES	☐ NO
Are you pregnant or trying to become pregnant?	☐ YES	☐ NO
Are you currently taking any prescription or non-prescription medications?	☐ YES	☐ NO

If yes, please list all medications:

Please indicate if you have experienced any of the following conditions:

- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Diabetes(Type I or Type II)
- ☐ Excessive Bleeding
- ☐ Epilepsy/Seizures
- ☐ Fainting or Dizziness
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis (A B C)
- ☐ High or Low Blood Pressure
- ☐ HIV+/AIDS
- ☐ Jaundice
- ☐ Joint Replacement (artificial joints)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Rheumatism/Arthritis
- ☐ Sinus Problems
- ☐ Ulcers/Gastric Reflux
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors/Cancer
- ☐ Other (please list below) ______________________

Please check if you are allergic to the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Sulfa
- ☐ Acetaminophen
- ☐ Latex
- ☐ Other ______________________________
- ☐ Clindamycin
- ☐ Penicillin

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.

______________________________ ______________________
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

1084 South High Street
Columbus, Ohio 43206
614.444.0417
germanvillagedentalgroup.com