ALLISON
& ASSOCIATES

MEDICAL HISTORY

PATIENT NAME:____
DOB:____

1. HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR IN THE LAST 2 YEARS? YES/NO
2. IF YES, NAME OF PHYSICIAN AND ADDRESS/PHONE/EMAIL?
   ____
   ____
   ____
3. HAVE YOU TAKEN ANY PRESCRIBED, OVER THE COUNTER, RECREATIONAL OR HERBAL MEDICINES, DRUGS OR CONCOCTIONS? YES/NO PLEASE LIST:____
   ____
   ____
   ____
   ____
   ____
   ____
   ______ ____
4. HAVE YOU BEEN TO THE ER IN THE LAST 2 YEARS? YES/NO IF YES, WHAT WAS YOUR CONDITION AND TREATMENT?
   ____
   ____
   ____
   __________ __________________
5. HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? YES/NO IF YES, WHAT WAS YOUR DIAGNOSIS AND TREATMENT?
   ____
   ____
   ____
   ____
   ____ ________________________
6. WOMEN: ARE YOU PREGNANT? YES/NO NURSING? YES/NO TAKING BIRTH CONTROL PILLS? YES/NO PERI-MENOPAUSAL/MENOPAUSAL? YES/ NO UNDERGOING BIO-IDENTICAL HORMONE REPLACEMENT THERAPY? YES/NO
   ____
   ____

7. ARE YOU ALLERGIC TO OR HAVE DIFFICULTY WITH ANY OF THE FOLLOWING:
    1. PENICILLIN YES/NO
    2. ASPIRIN YES/NO
    3. SULFA YES/NO
    4. TETRACYCLINE YES/NO
    5. CODEINE YES/NO
    6. ERYTHROMYCIN YES/NO
    7. LATEX YES/NO
    8. METALS YES/NO
    9. DENTAL ANESTHETIC YES/NO
    10. LACTOSE YES/NO

    11. FLUORIDE YES/NO
    12. OTHER DRUGS YES/NO PLEASE

    LIST:____
    ____
    _
    ____
    _ _______________

8. DO YOU EXERCISE REGULARLY? YES/NO HOW MUCH PER WEEK?
    ____
9. IS NUTRITION IMPORTANT TO YOUR? YES/NO HOW MANY SERVINGS OF FRUITS AND VEGETABLES DO YOU EAT PER DAY?
    ____
    _

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH 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 INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF CHANGE IN MY HEALTH OR MEDICATION.

SIGNATURE:_______________________________________DATE:____________
PARENT/GUARDIAN:________________________________DATE:____________