Douglas J Alterman
DMD PA

MEDICAL HISTORY **Patient Name:** _____

Primary Care Physician: _____

	Yes	No
1. Has there been any change in your general health within the past year?	☐	☐
If yes, for what? _____		
2. Are you currently under a physician's care for anything other than routine?	☐	☐
3. Have you had any serious illness or hospitalizations within the past (5) years?	☐	☐
If yes, for what? _____		

Indicate which of the following you have had or presently have:

YES	NO		YES	NO	
☐	☐	Heart (Surgery, Disease, Attack)	☐	☐	Tuberculosis
☐	☐	Rheumatic Fever or Rheumatic Heart Disease	☐	☐	Emphysema
☐	☐	Chest Pain, Angina	☐	☐	Sinus Trouble
☐	☐	High Blood Pressure	☐	☐	Asthma
☐	☐	Heart Murmur	☐	☐	Anemia
☐	☐	Mitral Valve Prolapse	☐	☐	Diabetes
☐	☐	Artificial Heart Valve	☐	☐	Arthritis/Rheumatism
☐	☐	Pacemaker	☐	☐	Kidney Trouble
☐	☐	Artificial Joints (hip, knee, etc.)	☐	☐	Epilepsy or Seizures
☐	☐	Alzheimer's Disease	☐	☐	HIV Positive
☐	☐	Hepatitis A,B,C,D,G	☐	☐	AIDS
☐	☐	Liver Disease	☐	☐	Drug Addiction
☐	☐	Cancer	☐	☐	Alcoholism
☐	☐	Chemotherapy	☐	☐	Tobacco Products
☐	☐	Radiation Therapy			

Other conditions not listed:

_____

(Continued on back)

Are you taking any of the following: (If "yes" state drug name)

YesNo
☐ ☐ Antibiotics
☐ ☐ Anticoagulants (blood thinners)
☐ ☐ High blood pressure medicine
☐ ☐ Bisphosphonates (medicine for osteoporosis)
☐ ☐ Aspirin
☐ ☐ Insulin
☐ ☐ Antihistamines
☐ ☐ Heart medications
☐ ☐ **Other Medications Please List:**

_____

Are you allergic or have you reacted adversely to:

YesNo
☐ ☐ Local anesthetics
☐ ☐ Penicillin or other antibiotics
☐ ☐ Aspirin
☐ ☐ Codeine, Demerol or other Narcotics
☐ ☐ Latex or rubber products
☐ ☐ Barbiturates, sedatives, or sleeping pills
☐ ☐ Sulfa
☐ ☐ **Other Medications Please List**:

_____

Women
1. Are you pregnant? **Yes** **No**

2. Are you taking birth control or hormone therapy? **Yes** **No**

Patient (or Guardian) Signature:

_____ **Date:** _____

Staff Signature: _____ **Date:** _____