Drs. Love & Miller, P.C.

Medical History

Patient Name *(Last, First, MI)* ______________________ Date ____________

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, for what? ______________________
   General Practitioner's name ______________________
   Specialist's Name and Specialty ______________________
2. Are you taking any medication, including blood thinners (i.e., Coumadin, Heparin)? ☐ Yes ☐ No
   If yes, please list name and dosage
   ____
3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No
   If yes, please list ______________________
4. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
   If yes, why? ______________________
5. Indicate which of the following you have had, or have at present:

Condition	Yes	No
A.I.D.S.	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Fainting or Dizzy Spells	☐ Yes	☐ No
Gastrointestinal Disorder	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Heart (Surgery, Attack)	☐ Yes	☐ No

Condition	Yes	No
Heart Murmur	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis A, B, or C	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
H.I.V. Positive	☐ Yes	☐ No
HPV Virus	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No
Latex Sensitivity	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous/Anxious	☐ Yes	☐ No
Neurological Disorders	☐ Yes	☐ No
Psychological Condition	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

6. Do you have or have you had any disease or condition not listed? ☐ Yes ☐ No
   If yes, please list ______________________
7. Are you pregnant? ☐ Yes, ___Months ☐ No | Nursing? ☐ Yes ☐ No | Taking birth control pills? ☐ Yes ☐ No

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 such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature ______________________ Date ____________

Dentist's Signature ______________________ Date ____________