Aliso Niguel Dental Group
including Orthodontics

# PATIENT MEDICAL HISTORY
(CONFIDENTIAL)

Patient Name: ________________________________________ Today's Date: ____________
Preferred Nickname: ____________________________________ Sex (circle) F M
Date of Birth: ____________________ Physician: ____________________________________
Physician address, phone: _______________________________________________________

Please list any medications you are currently taking: ______________________________
_______________________________________________________________________________
_______________________________________________________________________________

Describe any allergies/sensitivities to medications, environmental agents: _______________
_______________________________________________________________________________

Please list any hospitalizations, major illnesses: _________________________________
_______________________________________________________________________________

Do you smoke? ____________ How much? ________________________________________
Women: Are you pregnant? ______________ If so, delivery date: ________________________
Do you take birth control medications? ________________________________________

If you have, or ever have had, please check:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ❏ | ❏ | rheumatic fever | ❏ | ❏ | kidney disease/dialysis |
| ❏ | ❏ | heart murmer | ❏ | ❏ | liver disease |
| ❏ | ❏ | congenital heart defect | ❏ | ❏ | prosthetic valves, joints |
| ❏ | ❏ | other heart disease/surgery | ❏ | ❏ | blood disease, anemia |
| ❏ | ❏ | pacemaker | ❏ | ❏ | hemophilia |
| ❏ | ❏ | high blood pressure | ❏ | ❏ | AIDS/ARC/HIV positive |
| ❏ | ❏ | diabetes | ❏ | ❏ | asthma/lung disease |
| ❏ | ❏ | tuberculosis (TB) | ❏ | ❏ | bleeding problems |
| ❏ | ❏ | arthritis | ❏ | ❏ | radiation therapy |
| ❏ | ❏ | malignant hyperthermia | ❏ | ❏ | chemotherapy |
| ❏ | ❏ | hepatitis | ❏ | ❏ | immuno-suppression |
| ❏ | ❏ | indwelling catheter | ❏ | ❏ | history of "Phen-fen, Redux", |
| ❏ | ❏ | other disease or illness not listed (describe): | ❏ | ❏ | or phenfluramine therapy |

_____________________________________________________

Has pre-medication prior to dental treatment ever been recommended to you? ___________
Do you wish to discuss your medical history with the doctor in private? __________________

Signature ____________________________________________________________________