CASTOR
FAMILY DENTISTRY

MEDICAL HISTORY

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Last Name First Name M.I. DOB

1. Have you been under the care of a medical physician within the past 2 years? Y N
   If yes, for what? ____
   Physician's Name: ______________________ Phone: ______________________
   Address: ____
2. Do you take any drugs or medications (prescription and/or over-the-counter)? Y N
   Please list all drugs/medications including dosages on the attached page.
3. Have you ever had a substance abuse/ addiction issue? Y N
   ____
4. Do you have any allergies to any medications or substances? Y N
   If yes, please list and/or describe: ____
   ____
5. Have you been hospitalized for a surgery or serious illness within the last 5 years? Y N
   If yes, please describe: ____
   ____
6. Alcohol Consumption: _____ drinks per day OR _____ drinks per week
7. Smoking/ Tobacco _____ packs per day _____ years of use Other: ______________________
8. Women: Are you pregnant? Y N ___ months Nursing? Y N On Birth Control? Y N
9. Do you use more than 2 pillows to sleep at night? Y N
10. Have you lost or gained more than 10 pounds in the past year? Y N
11. Please indicate whether or not you have had, or currently have the following conditions:

Condition		Condition		Condition	
Heart (Surgery, Disease, Attack)	Y N	Ulcers	Y N	Hepatitis A B C	Y N
Chest Pain	Y N	Diabetes	Y N	Venereal Disease	Y N
Congenital Heart Disease	Y N	Thyroid Problems	Y N	HIV/ AIDS	Y N
Heart Murmur	Y N	Glaucoma	Y N	Cold Sores/ Fever Blisters	Y N
High Blood Pressure	Y N	Contact Lenses	Y N	Blood Transfusion	Y N
Mitral Valve Prolapse	Y N	Emphysema	Y N	Hemophilia	Y N
Artificial Heart Valve	Y N	Chronic Cough	Y N	Sickle Cell Disease/ Trait	Y N
Heart Pacemaker	Y N	Tuberculosis	Y N	Bruise Easily	Y N
Rheumatic Fever	Y N	Asthma	Y N	Liver Disease	Y N
Arthritis	Y N	Hay Fever	Y N	Yellow Jaundice	Y N
Cortisone Medication	Y N	Latex Sensitivity	Y N	Neurological Disease	Y N
Swollen Ankles	Y N	Allergies or Hives	Y N	Epilepsy or Seizures	Y N
Stroke	Y N	Sinus Trouble	Y N	Fainting or Dizzy Spells	Y N
Diet (restricted, specialized, etc.)	Y N	Radiation Therapy	Y N	Nervous/ Anxious	Y N
Artificial Joints (hip, knee, etc.)	Y N	Chemotherapy	Y N	Psychiatric/ Psychological Care	Y N
Kidney Trouble	Y N	Tumors	Y N		

12. Any other conditions, concerns, or issues not listed that you feel are important to address? Y N
    ____
    ____

I understand that 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 any change in my health or medication.

Patient/ Guardian Signature: ______________________________ Date: ______________