

Daniel H. Markham, D.M.D.  
Medical History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

1. Are you currently under the care of a physician? Yes: \_\_\_\_ No: \_\_\_\_  
If yes for: \_\_\_\_\_

2. Are you taking any medications? Yes: \_\_\_\_ No: \_\_\_\_  
If yes please list: \_\_\_\_\_

3. Are you allergic to any medications? Yes: \_\_\_\_ No: \_\_\_\_  
If yes please list: \_\_\_\_\_

4. Have you ever had a reaction to a local anesthetic? Yes: \_\_\_\_ No: \_\_\_\_  
If yes please describe: \_\_\_\_\_

5. *Women only:*

a. *Are you pregnant? Yes: \_\_\_\_ No: \_\_\_\_ Due Date : \_\_\_\_\_ -*

b. *Are you nursing? Yes: \_\_\_\_ No: \_\_\_\_*

c. *Are you taking birth control pills? Yes: \_\_\_\_\_ No: \_\_\_\_\_*

6. Do you need antibiotics before dental treatment? Yes: \_\_\_\_ No: \_\_\_\_  
If yes, for what condition: \_\_\_\_\_

7. HIPPA documents are available for you review. Please ask the receptionist if you would like to see these documents.

8. All requests for record transfers, including x-rays must be in writing and signed by the patient. (Parent or Legal Guardian for minors)

9. May we discuss your medical information with anyone, if so who?

\_\_\_\_\_

Medical History Page 2

Patient Name: \_\_\_\_\_

Please check if you have or have had any of the following:

- |                        |     |                                          |
|------------------------|-----|------------------------------------------|
| AIDS                   | ___ | Date of diagnosis: _____                 |
| Anemia                 | ___ | Type: _____                              |
| Artificial Joint       | ___ | Which joint? _____                       |
| Artificial Heart Valve | ___ | Date of surgery: _____                   |
| Asthma                 | ___ | Do you have an inhaler? _____            |
| Bleeding Problems      | ___ | Describe: _____                          |
| Breathing Problems     | ___ | Describe: _____                          |
| Cancer                 | ___ | Where: _____                             |
| Chemotherapy           | ___ | Date of Treatment: _____                 |
| Cortisone              | ___ | When did you take this medication? _____ |
| Diabetes               | ___ | Is it controlled with medication? _____  |
| Drug problems          | ___ | Name of drug: _____                      |
| Epilepsy               | ___ | Do you taken medication? _____           |
| Heart Murmur           | ___ | Do you need antibiotics? _____           |
| Heart Attack           | ___ | When? _____                              |
| Hepatitis              | ___ | Type: _____                              |
| High Blood Pressure    | ___ | Is it controlled with medication? _____  |
| Kidney Disease         | ___ | Describe: _____                          |
| Kidney Dialysis        | ___ | What days? _____                         |
| Latex Allergy          | ___ | Describe reaction: _____                 |
| Liver Disease          | ___ | Describe: _____                          |
| Mitral Valve Prolapse  | ___ | Did you have an echocardiogram? _____    |
| Radiation Treatment    | ___ | Where, When? _____                       |
| Rheumatic Fever        | ___ | When? _____                              |
| Stroke                 | ___ | Describe: _____                          |
| Thyroid Disease        | ___ | Medications? _____                       |

\_\_\_\_\_  
Patient Signature (If minor, Parent or Legal Guardian) Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_