

Long Island Family Dental, PC

900 Walt Whitman Rd, Suite 101

Melville, NY 11747

MEDICAL HISTORY FORM

Please print and answer all questions completely:

NAME: _____ DATE OF BIRTH: _____

Are you here for **EMERGENCY** care? **YES NO** Are you in pain? **YES NO** Are you in good health? **YES NO**

Please list and indicate dates for all hospitalizations and serious illnesses within the past 5 years:

Physician's Name: _____ Date of Last Physical: _____

Physician's Address: _____ Phone #: _____

Date of last dental exam: _____ Date of last full mouth x-rays: _____ Date of last medical x-rays: _____

Name and Number of Previous Dentist _____

Have you ever had or currently have any of the following conditions? (check box)

- Anemia
- Angina, Heart Attack
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints, Hip, Pins, etc.
- Asthma
- Autoimmune Disease
- Back Problems
- Bleeding Abnormally
- Blood Disease (hemophilia, etc.)
- Cancer
- Circulatory Problems
- Congenital Heart Problems
- Cortisone Treatments
- Cough, Persistent
- Cough up Blood
- Diabetes
- Epilepsy, Seizures
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Irregular Heart Beat
- Jaw Pain
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse
- Osteoporosis, Bone Disease
- Pacemaker
- Psychiatric Treatment, Diagnosis
- Radiation Therapy
- Chemotherapy
- Renal Dialysis
- Respiratory Disease
- Rheumatic/ Scarlet Fever
- Shortness of Breath
- Shunt (cranial, renal, etc)
- Skin Rash
- Stroke
- Swelling of ankles or feet
- Thyroid Problems
- Tobacco Habit
- Tuberculosis
- Ulcer
- Venereal Disease (STD)

Have you taken or are taking any of the following medications (circle)? **Aredia, Didronel, Fosamax, Actonel, Skelid** or "Fen-phen" type such as **Ionimin, Adipex, Fastin, Pondimin and Redux**.

Allergies (including to medications) _____

Please list ALL medications you are taking now: _____

Females Only: Are you currently Pregnant? **Yes or No** Do you take Birth Control Pills? **Yes or No**

To the best of my knowledge all of the preceding answers are accurate. If I have any change in my health or if my medications change, I will immediately inform the treating dentist at my next appointment.

Patient Signature	Date	Patient Signature	Date