Long Island Family Dental, PC
931 Walt Whitman Road

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:

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

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Please list ALL medications you are taking now: ____________________________________

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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 appointrnent.

Patient Signature	Date	Patient Signature	Date