Dr. Dan Dietz Medical History Form

Patient First Name ________________________________ Last Name________________________

1. Have you been treated by a medical doctor during the past two years? ……………(circle)   Yes   No

   If yes, reason for treatment____

   Physicians Name_________________________________ Phone_________________

2. Are you taking any medications? …………………………………………………………   Yes   No

If yes, list name of medicine and reason for taking them

Name	Reason

3. Have you had an allergic reaction to a medication? ……………………………(circle)   Yes   No

   If yes, please list: ____

4. Indicate which of the following you have had or have at present.   Check box for all those that apply.

☐ Heart Murmur	☐ Heart (surgery, disease, attack)	☐ Diabetes
☐ Ulcers	☐ High Blood Pressure	☐ Hepatitis
☐ Mitral Valve Prolapse	☐ Artificial Heart Valve	☐ Cortisone Medication
☐ Heart Pacemaker	☐ Hemophilia	☐ Stroke
☐ Latex Sensitivity	☐ Artificial Joints	☐ Liver Disease
☐ Sinus Infections	☐ Emphysema	☐ Epilepsy or Seizures
☐ Tuberculosis	☐ Asthma	☐ Neurological Disorders
☐ Cancer	☐ Psychiatric/Psychological Care	☐ Drug/Alcohol Dependence
☐ Chemotherapy	☐ Radiation Therapy	☐ Injury to Head/Neck/Teeth
☐ TMJ Problems		

5. **WOMEN:** Are you pregnant?   Yes,_____ Months   No   Uncertain

   Are you taking birth control pills?   Yes   No

6. Please list any disease, condition, or problem not listed: ______________________________

   ____

Patient/Person Completing Above/ **Signature**__________________________________Date__________

History Review

Dentist Signature____Date___________