BERKELEY DENTAL CARE
Your Dental Home

Medical History

Patient _____

Physician _____ Date Of Last Visit ___/___/___

Please list all medications you are currently taking with dosage:

_____

_____

List all allergies:

_____

Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Indicate which of the following you have had, or have at present? (Check all that apply).

□ AIDS	□ Circulatory Problems	□ Hepatitis	□ Scarlet Fever
□ Allergies or Hives	□ Cold Sores	□ High Blood Pressure	□ Shortness of Breath
□ Anemia	□ Cortisone Treatments	□ HIV Positive	□ Sinus Problems
□ Anxiety Problmes	□ Cough, Persistent	□ Jaw Pain	□ Skin Rash
□ Arthritis, Rheumatism	□ Cough up blood	□ Kidney Trouble	□ Stroke
□ Artificial Heart Valves	□ Diabetes	□ Latex Sensitivity	□ Swelling of Feet/Ankles
□ Artificial Joints	□ Epilepsy	□ Liver Disease	□ Thyroid Problems
□ Asthma	□ Fainting	□ Mitral Valve Prolapse	□ Tobacco Habit
□ Back Problems	□ Glaucoma	□ Neurological Problems	□ Tonsillitis
□ Blood Disease	□ Headaches	□ Pacemaker	□ Tuberculosis
□ Cancer	□ Heart Murmur	□ Psychiatric Care	□ Ulcers
□ Chemical Dependency	□ Heart problems	□ Radiation Treatment	□ Venereal disease
□ Chemotherapy	□ Hemophilia	□ Rheumatic Fever	

□ Other: _____

_____

Please describe any positive responses from the list above:

_____

_____

Do you smoke? □ Yes □ No Describe _____

Do you use alcohol? □ Yes □ No Describe _____

Do you use recreational drugs? □ Yes □ No Describe _____

Have you had surgery or been hospitalized in the last 5 years? □ Yes □ No Describe

_____

_____

Dentist's Signature _____ Date: ___/___/___

History Review _____ History Review _____ History Review _____ History Review _____