Clifford S. Litvak M.S., D.D.S.
ESTHETIC COMPREHENSIVE DENTISTRY

MEDICAL HISTORY

Name: _____ Date: _____

GENERAL HEALTH INFORMATION

YES	NO	DON'T KNOW	
☐	☐	☐	Do you have a personal physician? If so, please provide his/her name, address and phone number.
☐	☐	☐	Do you have any disease, handicapping condition, or disability which may interfere with the delivery of dental treatment? If so, please list.
☐	☐	☐	Have you ever been hospitalized or had a major operation? If so, please list.
☐	☐	☐	Have you ever had a serious injury to your head or neck? If so, please list.
☐	☐	☐	Are you on a special diet? If so, please describe.
☐	☐	☐	Are you satisfied with your eating patterns?

DRUGS AND MEDICATION

☐	☐	☐	Have you ever had an allergic or unusual reaction to any food, material, drug or medication? Please check box: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other (please list) _____
☐	☐	☐	Are you taking any drugs or medications prescribed by a health care provider or purchased over the counter at the present time? If so, please list. _____
☐	☐	☐	Are you taking or have you taken any recreational drugs? If so, please list.

WOMEN ONLY

☐	☐	☐	Are you pregnant at the present time? If yes, what month are you in? _____
☐	☐	☐	Are you trying to become pregnant?
☐	☐	☐	Are you taking birth control pills?
☐	☐	☐	Are you nursing?

Please check any of the following which you have had or have at the present. You must mark each question, please.

YES	NO	DON'T KNOW	
☐	☐	☐	AIDS
☐	☐	☐	Allergies (medicines)
☐	☐	☐	Allergies (pollen/dust)
☐	☐	☐	Alzheimer's Disease
☐	☐	☐	Anemia
☐	☐	☐	Angina / Chest pain
☐	☐	☐	Arthritis
☐	☐	☐	Artificial Joints
☐	☐	☐	Asthma
☐	☐	☐	Bleeding / Bruising
☐	☐	☐	Blood Disease
☐	☐	☐	Cancer
☐	☐	☐	Chemotherapy
☐	☐	☐	Congenital Heart Disease
☐	☐	☐	Convulsions
☐	☐	☐	Diabeties
☐	☐	☐	Difficulty Hearing
☐	☐	☐	Digestive Diseases
☐	☐	☐	Drug Addiction
☐	☐	☐	Emphysema
☐	☐	☐	Fainting or dizzyness
☐	☐	☐	Frequent Headaches
☐	☐	☐	Glaucoma
☐	☐	☐	Heart Attack or Disease
☐	☐	☐	Heart Murmur / Mitral Valve Prolapse
☐	☐	☐	Heart Surgery (any kind)
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis A B or C
☐	☐	☐	Hereditary Disease or Deformities
☐	☐	☐	High Blood Pressure
☐	☐	☐	HIV Positive
☐	☐	☐	Hospitalization
☐	☐	☐	Hypoglycemia
☐	☐	☐	Jaundice / Liver Disease
☐	☐	☐	Kidney Disease
☐	☐	☐	Leukemia
☐	☐	☐	Low Blood Pressure
☐	☐	☐	Nervous Problems
☐	☐	☐	Numbness or Tingling Sensations
☐	☐	☐	Oral Herpes
☐	☐	☐	Painful or Swollen Joints
☐	☐	☐	Paralysis
☐	☐	☐	Persistant Cough
☐	☐	☐	Psychiatric Care
☐	☐	☐	Radiation Therapy
☐	☐	☐	Recent Blood Transfusion
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Scarlet Fever
☐	☐	☐	Seizures or Epilepsy
☐	☐	☐	Shortness of Breath
☐	☐	☐	Sinus Problems
☐	☐	☐	Steroid Therapy
☐	☐	☐	Stroke
☐	☐	☐	Thyroid Disease
☐	☐	☐	Tuberculosis
☐	☐	☐	Tumors or Growths
☐	☐	☐	Ulcers
☐	☐	☐	Venereal Diseases
☐	☐	☐	Vision Changes

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YES	NO	DON'T KNOW	
☐	☐	☐	Do you have any medical condition not listed in any of the questions? If so, please list.

To the best of my knowledge the health information presented above is an accurate representation of my, or my named minor child's or guardian's present health status as of this date. If, in the event that there is any change in my health status or medications, I will inform the dentist and staff before any treatment is started.

Patient signature (parent or guardian) Date:

Reviewed by: Date:

PATIENT RESUME *(completed by dental personnel)*

ASA Class I II III IV

Past Medical History:

Medical Precautions and Alerts:

MEDICAL CHANGES AND UPDATES

I have reviewed my MEDICAL HISTORY and confirm that it adequately states past and present conditions except as noted below. *(completed by patient and dental personnel)*

Date	Change	Patient Signature	Reviewed By