

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Dental personnel primarily treat the area in and around the mouth. However, as your mouth is part of your entire body, health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes ___ No ___ If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes ___ No ___ If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes ___ No ___ If yes, please explain: _____

Are you taking any medications, pills or drugs? Yes ___ No ___ If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes ___ No ___

Are you on a special diet? Yes ___ No ___

Do you use tobacco? Yes ___ No ___

Do you use controlled substances? Yes ___ No ___

Women: Are you...

Pregnant/Trying to get pregnant? Yes ___ No ___ Taking Oral Contraceptives? Yes ___ No ___ Nursing? Yes ___ No ___

Are you allergic to any of the following?

Aspirin? Yes ___ No ___ Penicillin? Yes ___ No ___ Codeine? Yes ___ No ___ Local Anesthetics? Yes ___ No ___
 Latex? Yes ___ No ___ Acrylic? Yes ___ No ___ Metal? Yes ___ No ___ Other? _____

Do you have, or have you had, any of the following?

AIDS/HIV positive	Yes ___ No ___	Cortisone Medicine	Yes ___ No ___	Hemophilia	Yes ___ No ___	Renal Dialysis	Yes ___ No ___
Alzheimer's Disease	Yes ___ No ___	Diabetes	Yes ___ No ___	Hepatitis A	Yes ___ No ___	Rheumatic Fever	Yes ___ No ___
Anaphylaxis	Yes ___ No ___	Drug Addiction	Yes ___ No ___	Hepatitis B or C	Yes ___ No ___	Rheumatism	Yes ___ No ___
Anemia	Yes ___ No ___	Easily Winded	Yes ___ No ___	Herpes	Yes ___ No ___	Scarlet Fever	Yes ___ No ___
Angina	Yes ___ No ___	Emphysema	Yes ___ No ___	High Blood Pressure	Yes ___ No ___	Shingles	Yes ___ No ___
Arthritis/Gout	Yes ___ No ___	Epilepsy or Seizures	Yes ___ No ___	Hives or Rash	Yes ___ No ___	Sickle Cell Disease	Yes ___ No ___
Artificial Heart Valve	Yes ___ No ___	Excessive Bleeding	Yes ___ No ___	Hypoglycemia	Yes ___ No ___	Sinus Trouble	Yes ___ No ___
Artificial Joint	Yes ___ No ___	Excessive Thirst	Yes ___ No ___	Irregular Heartbeat	Yes ___ No ___	Spina Bifida	Yes ___ No ___
Asthma	Yes ___ No ___	Fainting Spells/Dizziness	Yes ___ No ___	Kidney Problems	Yes ___ No ___	Stomach/Intestinal Disease	Yes ___ No ___
Blood Disease	Yes ___ No ___	Frequent Cough	Yes ___ No ___	Leukemia	Yes ___ No ___	Stroke	Yes ___ No ___
Blood Transfusion	Yes ___ No ___	Frequent Diarrhea	Yes ___ No ___	Liver Disease	Yes ___ No ___	Swelling of Limbs	Yes ___ No ___
Breathing Problem	Yes ___ No ___	Frequent Headaches	Yes ___ No ___	Low Blood Pressure	Yes ___ No ___	Thyroid Disease	Yes ___ No ___
Bruise Easily	Yes ___ No ___	Genital Herpes	Yes ___ No ___	Lung Disease	Yes ___ No ___	Tonsillitis	Yes ___ No ___
Cancer	Yes ___ No ___	Glaucoma	Yes ___ No ___	Mitral Valve Prolapse	Yes ___ No ___	Tuberculosis	Yes ___ No ___
Chemotherapy	Yes ___ No ___	Hay Fever	Yes ___ No ___	Pain in Jaw Joints	Yes ___ No ___	Tumors or Growths	Yes ___ No ___
Chest Pains	Yes ___ No ___	Heart Attack/Failure	Yes ___ No ___	Parathyroid Disease	Yes ___ No ___	Ulcers	Yes ___ No ___
Cold Sores/Fever Blisters	Yes ___ No ___	Heart Murmur	Yes ___ No ___	Psychiatric Care	Yes ___ No ___	Venereal Disease	Yes ___ No ___
Congenital Heart Disorder	Yes ___ No ___	Heart Pace Maker	Yes ___ No ___	Radiation Treatments	Yes ___ No ___	Yellow Jaundice	Yes ___ No ___
Convulsions	Yes ___ No ___	Heart Trouble/Disease	Yes ___ No ___	Recent Weight Loss	Yes ___ No ___		

Have you ever had a serious illness not listed above? Yes ___ No ___ If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE: _____