

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication 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? Nursing?
 Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

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

- AIDS/HIV Positive Chest Pains Frequent Headaches Irregular Heartbeat Scarlet Fever
- Alzheimer's Disease Cold Sores/Fever Blisters Genital Herpes Kidney Problems Shingles
- Anaphylaxis Congenital Heart Disorder Glaucoma Leukemia Sickle Cell Disease
- Anemia Convulsions Hay Fever Liver Disease Sinus Trouble
- Angina Cortisone Medicine Heart Attack/Failure Low Blood Pressure Spina Bifida
- Arthritis/Gout Diabetes Heart Murmur Lung Disease Stomach/Intestinal Disease
- Artificial Heart Valve Drug Addiction Heart Pace Maker Mitral Valve Prolapse Stroke
- Artificial Joint Easily Winded Heart Trouble/Disease Pain in Jaw Joints Swelling of Limbs
- Asthma Emphysema Hemophilia Parathyroid Disease Thyroid Disease
- Blood Disease Epilepsy or Seizures Hepatitis A Psychiatric Care Tonsillitis
- Blood Transfusion Excessive Bleeding Hepatitis B or C Radiation Treatments Tuberculosis
- Breathing Problem Excessive Thirst Herpes Recent Weight Loss Tumors or Growths
- Bruise Easily Fainting Spells/Dizziness High Blood Pressure Renal Dialysis Ulcers
- Cancer Frequent Cough Hives or Rash Rheumatic Fever Venereal Disease
- Chemotherapy Frequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice

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

Comments: _____

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 _____