MEDICAL HISTORY

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.

Patient name____________________________________ Date of Birth______________________________

Are you under a physician's care now? ? yes ? no If yes____________________

Have you ever been hospitalized or had a major operation? ? yes ? no If yes____________________

Have you ever had a serious head or neck injury? ? yes ? no If yes____________________

Are you taking any medication, pills, or drugs? ? yes ? no If yes____________________

Do you take, or have you taken, Phen-Fen or Redux? ? yes ? no If yes____________________

Are you on a special diet? ? yes ? no

Do you use tobacco? ? yes ? no

Do you use controlled substances? ? yes ? no If yes____________________

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 ? Sulfa Drugs ? Local Anesthetics

? Other Please explain____

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

AIDS/HIV Positive ☐ yes ☐ no
Alzheimer’s Disease ☐ yes ☐ no
Anaphylaxis ☐ yes ☐ no
Anemia ☐ yes ☐ no
Angina ☐ yes ☐ no
Arthritis/Gout ☐ yes ☐ no
Artificial Heart Valve ☐ yes ☐ no
Asthma ☐ yes ☐ no
Blood Transfusion ☐ yes ☐ no
Breathing Problems ☐ yes ☐ no
Bruise Easily ☐ yes ☐ no
Cancer ☐ yes ☐ no
Chemotherapy ☐ yes ☐ no
Chest Pains ☐ yes ☐ no
Cold Sores/Fever Blisters ☐ yes ☐ no
Congenital Heart Disorder ☐ yes ☐ no
Convulsions ☐ yes ☐ no
Cortisone Medicine ☐ yes ☐ no
Diabetes ☐ yes ☐ no
Drug Addiction ☐ yes ☐ no
Easily Winded ☐ yes ☐ no
Emphysema ☐ yes ☐ no
Epilepsy or Seizures ☐ yes ☐ no
Excessive Bleeding ☐ yes ☐ no
Excessive Thirst ☐ yes ☐ no
Fainting Spells/ Dizziness ☐ yes ☐ no
Frequent Cough ☐ yes ☐ no
Frequent Diarrhea ☐ yes ☐ no
Frequent Headaches ☐ yes ☐ no
Genital Herpes ☐ yes ☐ no
Glaucoma ☐ yes ☐ no
Hay Fever ☐ yes ☐ no
Heart Attack/Failure ☐ yes ☐ no
Heart Murmur ☐ yes ☐ no
Heart Pacemaker ☐ yes ☐ no
Heart Trouble/Disease ☐ yes ☐ no
Hemophilia ☐ yes ☐ no
Hepatitis A ☐ yes ☐ no
Hepatitis B or C ☐ yes ☐ no
Herpes ☐ yes ☐ no
High Blood Pressure ☐ yes ☐ no
High Cholesterol ☐ yes ☐ no
Hives or Rash ☐ yes ☐ no
Hypoglycemia ☐ yes ☐ no
Irregular Heartbeat ☐ yes ☐ no
Kidney Problems ☐ yes ☐ no
Leukemia ☐ yes ☐ no
Liver Disease ☐ yes ☐ no
Low Blood Pressure ☐ yes ☐ no
Lung Disease ☐ yes ☐ no
Mitral Valve Prolapse ☐ yes ☐ no

Condition		Condition		Condition	
Osteoporosis	? yes ? no	Scarlet Fever	? yes ? no	Thyroid Disease	? yes ? no
Pain in Jaw Joints	? yes ? no	Shingles	? yes ? no	Tonsilitis	? yes ? no
Parathyroid Disease	? yes ? no	Sickle Cell Disease	? yes ? no	Tuberculosis	? yes ? no
Psychiatric Care	? yes ? no	Sinus Trouble	? yes ? no	Tumors or Growths	? yes ? no
Radiation Treatments	? yes ? no	Spina Bifida	? yes ? no	Ulcers	? yes ? no
Recent Weight Loss	? yes ? no	Stomach or Intestinal Disease	? yes ? no	Venereal Disease	? yes ? no
Renal Dialysis	? yes ? no	Stroke	? yes ? no	Yellow Jaundice	? yes ? no
Rheumatism	? yes ? no	Swelling of Limbs	? yes ? no		

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________________________