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: ______________________________

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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: ____________________