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○
Do you need to pre-medicate? Yes● No○ If yes, please explain: _____

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☐ 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	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 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 _____

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