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? ☐ Yes ☐ No 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?

☐ Yes ☐ No 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 Artificial Joint
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Disease

☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Breathing Problem
☐ 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 Pace Maker
☐ 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 Hives or Rash
☐ Yes ☐ No Hypoglycemia

☐ Yes ☐ No Irregular Heart Beat
☐ 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 Pain in Jaw Joints
☐ Yes ☐ No Parathyroid Disease
☐ Yes ☐ No Psychiatric Care

☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Recent Weight Loss
☐ Yes ☐ No Renal Dialysis
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Rheumatism

☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sickle Cell Disease
☐ Yes ☐ No Sinus Trouble
☐ Yes ☐ No Spina Bifida

☐ Yes ☐ No Stomach/Intestinal Disease
☐ Yes ☐ No Stroke
☐ Yes ☐ No Swelling of Limbs
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Tonsillitis

☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Tumors or Growths
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Yellow Jaundice

Have you ever had any 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

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