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 need to pre-medicate? Yes No If yes, please explain what for:_____
Did you take your Pre-Medication today? Yes No
Do you use controlled substances? Yes No

Have you ever been diagnosed with cancer? Yes No If yes, what type?:_____
If yes, what medications/treatments did you receive? _____
Have you been given any injections/medications to strengthen your bones? Yes No If yes, please explain:_____
Have you been given any bisphosphonate medications, such as Reclast? Yes No If yes, please explain:_____

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:

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	If diabetic, most recent A1C_____			Hepatitis B or C	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Drug Addiction	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Easily Winded	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Emphysema	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Excessive Thirst	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Autoimmune Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Lymphoma	Yes	No	Swelling of Limbs	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Liver Disease	Yes	No	Thyroid Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Tonsillitis	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Lung Disease	Yes	No	Tuberculosis	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tumors or Growths	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Osteoporosis	Yes	No	Ulcers	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Pain in Jaw Joints	Yes	No	Yellow Jaundice	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Parathyroid Disease	Yes	No			
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Psychiatric Care	Yes	No			
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Radiation Treatments	Yes	No			

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

Women: Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives: Yes No Nursing? Yes No

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_____

FOR STAFF USE ONLY

Blood Pressure:_____ Pulse:_____

High_____ Low_____

Comments:_____

_____

_____

OVER→