



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.

<ul style="list-style-type: none"> - Are you under a physician's care now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ - Have you ever been hospitalized or had a major operation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ - Have you ever had a serious head or neck injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ - Are you currently on any medications including nonprescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ - Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ - Do you take, or have you taken, Phen-Fen or Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No - Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No - Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No 	<p>Women: Are you</p> <input type="checkbox"/> Pregnant/Trying to get pregnant? <input type="checkbox"/> Taking oral contraceptives? <input type="checkbox"/> Nursing?
---	--

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Other, please explain: _____
--

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

<input type="checkbox"/> AIDS/HIV Positive <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Artificial Joint <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Breathing Problem <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Sores/Fever Blisters <input type="checkbox"/> Congenital Heart Disorder <input type="checkbox"/> Convulsions <input type="checkbox"/> Cortisone Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Easily Winded <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Fainting Spells/Dizziness <input type="checkbox"/> Frequent Cough <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hay Fever <input type="checkbox"/> Heart Attack/Failure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Pace Maker <input type="checkbox"/> Heart Trouble/Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hives or Rash <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver Disease	<input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pain in Jaw Joints <input type="checkbox"/> Parathyroid Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatments <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shingles <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Stomach/Intestinal Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Limbs <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors or Growth <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Yellow Jaundice
---	--	--	--	--

<p>Have you ever had any serious illness not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Please Explain: _____</p> <p>_____</p>
--

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: _____