Medical History

First Name:_____**Last Name:**_____**Birth Date**:_____

Although dental personnel primarily treat the area in and around your mouth, 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 receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐Yes ☐No	If yes, explain:_____
Have you been hospitalized or had a major operation?	☐Yes ☐No	If yes, explain:_____
Have you even had a serious head or neck injury?	☐Yes ☐No	If yes, explain:_____
Are you taking any medications, pills, or drugs?	☐Yes ☐No	If yes, explain:_____
Do you take, or have taken, Phen-Fen or Redux?	☐Yes ☐No	If yes, explain:_____
Are you on a special diet?	☐Yes ☐No	If yes, explain:_____
Do you use tobacco?	☐Yes ☐No	If yes, explain:_____
Do you use controlled substances?	☐Yes ☐No	If yes, explain:_____
Do you have frequent headaches?	☐Yes ☐No	If yes, explain:_____
Do you have sensitive teeth?	☐Yes ☐No	If yes, explain:_____

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metals ☐Latex ☐Local Anesthetics

☐Other Please explain:_____

Women - Are You:

☐Pregnant / Trying to get pregnant ☐Nursing ☐Taking oral contraceptives

Check any that apply

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

Have you ever had a serious illness not listed above? If yes, 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 or Patient's Guardian: _____Date:_____