

**MEDICAL HISTORY**

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/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

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 Heartbeat  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 Treatments  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  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 \_\_\_\_\_