

**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/Trying to get pregnant? Nursing?  
 Taking oral contraceptives?

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

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