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 controlled substances?	❑ Yes	❑ No	Women: Are you
Have you been advised to take pre-med before dental visits?	❑ Yes	❑ No	❑ 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	❑ Cold Sores/Fever Blisters	❑ Heart Attack/Failure	❑ Liver Disease	❑ Sinus Trouble
❑ Alzheimer's Disease	❑ Congenital Heart Disorder	❑ Heart Murmur	❑ Low Blood Pressure	❑ Snoring
❑ Anaphylaxis	❑ Convulsions	❑ Heart Pace Maker	❑ Lung Disease	❑ Spina Bifida
❑ Anemia	❑ Cortisone Medicine	❑ Heart Trouble/Disease	❑ Mitral Valve Prolapse	❑ Stomach/Intestinal Disease
❑ Angina	❑ Diabetes	❑ Hemophilia	❑ Osteoporosis	❑ Stroke
❑ Arthritis/Gout	❑ Drug Addiction	❑ Hepatitis A	❑ Pain in Jaw Joints	❑ Swelling of Limbs
❑ Artificial Heart Valve	❑ Easily Winded	❑ Hepatitis B or C	❑ Parathyroid Disease	❑ Thyroid Disease
❑ Artificial Joint	❑ Emphysema	❑ Herpes	❑ Psychiatric Care	❑ Tonsillitis
❑ Asthma	❑ Epilepsy or Seizures	❑ High Blood Pressure	❑ Radiation Treatments	❑ Tuberculosis
❑ Blood Disease	❑ Excessive Bleeding	❑ High Cholesterol	❑ Recent Weight Loss	❑ Tumors or Growths
❑ Blood Transfusion	❑ Excessive Thirst	❑ Hives or Rash	❑ Renal Dialysis	❑ Ulcers
❑ Breathing Problem	❑ Fainting Spells/Dizziness	❑ Human Pappilloma Virus	❑ Rheumatic Fever	❑ Yellow Jaundice
❑ Bruise Easily	❑ Frequent Cough	❑ Hypoglycemia	❑ Rheumatism	
❑ Cancer	❑ Frequent Headaches	❑ Irregular Heartbeat	❑ Scarlet Fever	
❑ Chemotherapy	❑ Glaucoma	❑ Kidney Problems	❑ Shingles	
❑ Chest Pains	❑ Hay Fever	❑ Leukemia	❑ Sickle Cell Disease	

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

Comments: ______

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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 ______