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/surgery?	❑ 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	_____
Have you had Botox/Fillers?	❑ 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?

❑ ADD/ADHD/ASD	❑ Chest Pains	❑ Glaucoma/Blindness	❑ Kidney Problems	❑ Sickle Cell Disease
❑ AIDS/HIV Positive	❑ Cold Sores/Fever Blisters	❑ Hay Fever	❑ Leukemia	❑ Sinus Trouble
❑ Alzheimer's Disease	❑ Congenital Heart Disorder	❑ Heart Attack/Failure	❑ Liver Disease	❑ Spina Bifida
❑ Anaphylaxis	❑ Convulsions	❑ Heart Murmur	❑ Low Blood Pressure	❑ Stomach/Intestinal Disease
❑ Anemia	❑ Cortisone Medicine/Steroids	❑ Heart Pace Maker	❑ Lung Disease/COPD	❑ Stroke
❑ Angina	❑ Dementia	❑ Heart Trouble/Disease	❑ Mitral Valve Prolapse	❑ Swelling of Limbs
❑ Arthritis/Gout	❑ Diabetes	❑ Hemophilia	❑ Osteoporosis	❑ Thyroid Disease
❑ Artificial Heart Valve	❑ Drug Addiction	❑ Hepatitis A	❑ Pain in Jaw Joints	❑ Tonsillitis
❑ Artificial Joint	❑ Emphysema	❑ Hepatitis B or C	❑ Parathyroid Disease	❑ Tuberculosis
❑ Asthma	❑ Epilepsy or Seizures	❑ Herpes	❑ Parkinson's/MS	❑ Tumors or Growths
❑ Blood Disease	❑ Excessive Bleeding	❑ High Blood Pressure	❑ Psychiatric Care	❑ Ulcers
❑ Blood Transfusion	❑ Excessive Thirst	❑ High Cholesterol	❑ Radiation Treatments	
❑ Breathing Problem	❑ Fainting Spells/Dizziness	❑ Hives or Rash	❑ Recent Weight Loss	
❑ Bruise Easily	❑ Fosamax/Bone-building Drugs	❑ Human Pappilloma Virus	❑ Renal Dialysis	
❑ Cancer	❑ Frequent Cough	❑ Hypoglycemia	❑ Rheumatism	
❑ Chemotherapy	❑ Frequent Headaches	❑ Irregular Heartbeat	❑ Shingles	

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 _____