PATIENT MEDICAL HISTORY

For

Name: ________________________________

Birth Date: ___________________

Although, as dental professionals we primarily treat the area in and around your mouth, your mouth is part of the entire body. Health problems that you may have or medications 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? If yes, please explain: ________________________________

Have you ever been hospitalized or had a major operation? If yes, please explain: ________________________________

Have you ever had a serious neck or head injury? If yes, please explain: ________________________________

Are you taking any medications, pills, or drugs? 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 . . . . . Mark a check mark against the following only if you answer "Yes".

___Pregnant/Trying to get pregnant? ___Taking oral contraceptives? ___Nursing?

Are you allergic to any of the following? Mark a check mark against the following only if you answer "Yes".

__Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics

__Other If yes, please explain: ____

Do you have, or have had any of the following? Mark a check mark against the following only if you answer "Yes".

___AIDS/HIV Positive
___Alzheimer's Disease
___Anaphylaxis
___Anemia
___Angina
___Arthritis/Gout
___Artificial Heart Valv
___Artificial Joint
___Asthma
___Blood Disease
___Blood Transfusion
___Breathing Problem
___Bruise Easily
___Cancer
___Chemotherapy
___Chest Pain
___Cold Sores
___Congenital Heart Di:
___Convulsions
___Cortisone Medicine
___Diabetes
___Drug Addiction
___Easily Winded
___Emphysema
___Epilepsy or Seizures
___Excessive Bleeding
___Excessive Thirst
___Fainting Spells
___Frequent Cough
___Frequent Diarrhea
___Frequent Headaches
___Genital Herpes
___Glaucoma
___Hay Fever
___Heart Attack/Failure
___Heart Murmur
___Heart Pace Maker
___Heart 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 Pressure
___Lung Disease
___Mitral Valve Prolapse
___Pain in Jaw Joints
___Parathryoid 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 of Limbs
___Thyroid Disease
___Tonsilitis
___Tuberculosis
___Tumors or Growths
___Ulcers
___Veneral Disease
___Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please 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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian ______________________________________ Date ________________