

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
 Have you ever been hospitalized or had a major operation? Yes No
 Have you ever had a serious head or neck injury? Yes No
 Are you taking any medications, pills, or drugs? Yes No
 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

If yes, please explain: _____

- Women: Are you: Nursing?
 Pregnant/ Trying to get pregnant?
 Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other Please explain: _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Yes No 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 patient's) health. It is my responsibility to inform the dental office of any changed in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____