

MEDICAL HISTORY

Patient Name _____

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 Condition being treated: _____

Have you ever been hospitalized/had major surgery? Yes No _____

Have you ever had a serious head/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 Do you use tobacco? Yes No

Do you take, or have you taken drugs to increase bone density such as: Aredia, Zometa, Fosomax or Actonel? Yes No Do you use controlled substances? Yes No

Women: Are you Pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

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

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

*Condition may require medication

Have you ever had any serious illness not listed above? Yes No _____

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