## Medical History

Patient Name:______________________ Date:___________

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.

| | Yes | No | |
|---|---|---|---|
| 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: |
| Do you suffer from frequent, chronic or migraine headaches? | | | If yes, please explain: |
| Are you taking any medication, pills or drugs? | | | If yes, please explain: |
| Do you take or have you taken Phen-fen or Redux? | | | |
| Do you take or have you taken bisphosphonates? | | | |
| Do you use tobacco? | | | |
| Do you use controlled substances? | | | |
| Women: Are you pregnant or trying to get pregnant? | | | Taking Oral Contraceptives: Y N |

Are you allergic to any of the following?

| Aspirin | Penicillin | Codeine | Acrylic | Metal | Latex | Local Anesthetic | Other: |
|---|---|---|---|---|---|---|---|

|  | Yes | No |  | Yes | No |  | Yes | No |  | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aids/HIV |  |  | Cortisone Medicine |  |  | Hemophilia |  |  | Dialysis |  |  |
| Alzheimer's Disease |  |  | Diabetes |  |  | Hepatitis A |  |  | Rheumatic Fever |  |  |
| Anaphylaxis |  |  | Drug Addiction |  |  | Hepatitis B |  |  | Rheumatism |  |  |
| Anemia |  |  | Easily Winded |  |  | Hepatitis C |  |  | Scarlet Fever |  |  |
| Angina |  |  | Emphysema |  |  | High Blood Pressure |  |  | Shingles |  |  |
| Arthritis/Gout |  |  | Epilepsy/Seizures |  |  | Hives or Rash |  |  | Sickle Cell Disease |  |  |
| Artificial Heart Valve |  |  | Excessive Bleeding |  |  | Hypoglycemia |  |  | Sinus Trouble |  |  |
| Artificial Joint |  |  | Excessive Thirst |  |  | Irregular Heart Beat |  |  | Spina Bifida |  |  |
| Asthma |  |  | Fainting/Dizziness |  |  | Kidney Problems |  |  | Stomach/Intestinal Disease |  |  |
| Blood Disease |  |  | Frequent Cough |  |  | Leukemia |  |  | Stroke |  |  |
| Blood Transfusion |  |  | Frequent Diarrhea |  |  | Liver Disease |  |  | Swelling of Limbs |  |  |
| Breathing Problem |  |  | Frequent Headaches |  |  | Low Blood Pressure |  |  | Thyroid Disease |  |  |
| Bruise Easily |  |  | Genital Herpes |  |  | Lung Disease |  |  | Tonsillitis |  |  |
| Cancer |  |  | Glaucoma |  |  | Mitral Valve Prolapse |  |  | Tuberculosis |  |  |
| Chemotherapy |  |  | Hay Fever |  |  | Pain in Jaw Joints |  |  | Tumors or Growths |  |  |
| Chest Pains |  |  | Heart Attack/Failure |  |  | Parathyroid Disease |  |  | Ulcers |  |  |
| Cold Sores/Fever Blisters |  |  | Heart Murmur |  |  | Psychiatric Care |  |  | Venereal Disease |  |  |
| Congenital Heart Disorder |  |  | Heart Pace Maker |  |  | Radiation Treatments |  |  | Yellow Jaundice |  |  |
| Convulsions |  |  | Heart Trouble/Disease |  |  | Recent Weight Loss |  |  |  |  |  |

Have you 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 patient's) health. It is my responsibility to inform the dental office of any changes in my health status and medications.

Signature of Patient, Parent or Guardian:
____________________________________________________

Date: ____________