MEDICAL HISTORY

Patient Name:_____ **Birthdate:**_____

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.

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN IN THE SPACE PROVIDED:

	YES	NO
Are you under a physician's care now? _____	___	___
Have you ever been hospitalized or had a major operation? _____	___	___
Do you take any blood thinners or antiplatelet medications? _____	___	___
Are you taking any medications, pills, or drugs? _____	___	___
If yes, please provide a MED LIST: _____		
Do you take, or have you taken Phen-Fen or Redux? _____	___	___
Do you take any medication for osteoporosis (i.e. Fosamax)_____	___	___
Have you had a total or partial joint replacement? i.e. knee, hip, or shoulder? _____	___	___
Do you use tobacco? _____	___	___
Do you use controlled substances? _____	___	___

*__WOMEN__, are you: (circle all that apply) Pregnant Trying to get pregnant Taking oral contraceptives Nursing

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal ___Latex
___Sulfa Drugs ___Erythromycin ___Other If yes, please explain:_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

	YES NO		YES NO		YES NO		YES NO
AIDS/HIV positive	___ ___	Emphysema	___ ___	Irregular Heartbeat	___ ___	Thyroid Disease	___ ___
Alzheimer's Disease	___ ___	Epilepsy or Seizures	___ ___	Kidney Problems	___ ___	Tuberculosis	___ ___
Anaphylaxis	___ ___	Excessive Bleeding	___ ___	Leukemia	__ ___	Tumors/Growths	___ ___
Anemia	___ ___	Excessive Thirst	___ ___	Liver Disease	___ ___	Ulcers	___ ___
Angina	___ ___	Fainting Spells/Dizziness	___ ___	Low Blood Pressure	___ ___	Venereal Disease	___ ___
Arthritis/Gout	___ ___	Frequent Cough	___ ___	Lung Disease	___ ___	Yellow Jaundice	___ ___
Artificial Heart Valve	___ ___	Frequent Diarrhea	___ ___	Mitral Valve Prolapse	___ ___		
Artificial Joint	___ ___	Frequent Headaches	___ ___	Osteoporosis	___ ___		
Asthma	___ ___	Genital Herpes	___ ___	Pain in Jaw Joints	___ ___		
Blood Disease	___ ___	Glaucoma	___ ___	Parathyroid Disease	___ ___		
Blood Transfusion	___ ___	Hay Fever	___ ___	Psychiatric Care	___ ___	**Have you had any serious illness**	
Breathing Problem	___ ___	Heart Attack/ Failure	___ ___	Radiation Treatment	___ ___	**not listed above?**_____	
Bruise Easily	___ ___	Heart Murmur	___ ___	Recent Weight Loss	___ ___	_____	
Cancer	___ ___	Heart Pacemaker	___ ___	Renal Dialysis	___ ___	_____	
Chemotherapy	___ ___	Heart Trouble/ Disease	___ ___	Rheumatic Fever	___ ___	_____	
Chest Pains	___ ___	Hemophilia	___ ___	Rheumatism	___ ___	_____	
Cold Sores	___ ___	Hepatitis A	___ ___	Scarlet Fever	___ ___	_____	
Congenital Heart Disorder	___ ___	Hepatitis B or C	___ ___	Shingles	___ ___	_____	
Convulsions	___ ___	Herpes	___ ___	Sickle Cell Disease	___ ___	_____	
Cortisone Medicine	___ ___	High Blood Pressure	___ ___	Sinus Trouble	___ ___	**Comments:**_____	
Diabetes	___ ___	High Cholesterol	___ ___	Stomach Problems	___ ___	_____	
Drug Addiction	___ ___	Hives or Rash	___ ___	Stroke	___ ___	_____	
Easily Winded	___ ___	Hypoglycemia	___ ___	Swelling of Limbs	___ ___	_____	

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

Signature of Patient, Parent, or Guardian_____ **Date:**_____

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