MEDICAL HISTORY

PATIENT NAME _____ Birth 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.

Are you under a physician's care now? [Yes] [No] If yes, please explain: _____
Have you ever been hospitalized or had a major operation? [Yes] [No] If yes, please explain: _____
Have you ever had a serious head or neck injury? [Yes] [No] If yes, please explain: _____
Are you taking any medications, pills, or drugs? [Yes] [No] 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]
Do you need to pre-medicate? [Yes] [No] If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

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

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

Have you ever had any serious illness not listed above? [Yes] [No] If yes, please explain: _____
_____
_____

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 _____

Medication History

Drug Name	Dosage	Frequency	Date started	Date ended or Current

Signature