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 question.

1. Are you under a physicians care now? Y N
2. Have you ever been hospitalized or had a major operation? Y N
3. Have you ever had a serious head or neck injury? Y N
4. Are you taking any medications, pills, or drugs? Y N
5. Do you take, or have you taken Phen-Fen or Redux? Y N
6. Are you on a special diet? Y N
7. Do you use tobacco? Y N
8. Do you use controlled substances? Y N

If 'Yes' to any of the above questions, please explain:

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Women: Are you…

Pregnant / Trying to get pregnant? Y N

Taking oral contraceptives? Y N

Nursing? Y N

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

AIDS/HIV Positive	Y	N	______________________________
Alzheimer's Disease	Y	N	______________________________
Anaphylaxis	Y	N	______________________________
Anemia	Y	N	______________________________
Angina	Y	N	______________________________
Arthritis/Gout	Y	N	______________________________
Artificial Heart Valve	Y	N	______________________________
Artificial Joint	Y	N	______________________________
Asthma	Y	N	______________________________
Blood Disease	Y	N	______________________________
Blood Transfusion	Y	N	______________________________
Breathing Problem	Y	N	______________________________

Bruise Easily	Y	N	________________________________
Cancer	Y	N	________________________________
Chemotherapy	Y	N	________________________________
Chest Pains	Y	N	________________________________
Cold Sores/Fever Blisters	Y	N	________________________________
Congenital Heart Disorder	Y	N	________________________________
Convulsions	Y	N	________________________________
Cortisone Medicine	Y	N	________________________________
Diabetes	Y	N	________________________________
Drug Addiction	Y	N	________________________________
Easily Winded	Y	N	________________________________
Emphysema	Y	N	________________________________
Epilepsy or Seizures	Y	N	________________________________
Excessive Bleeding	Y	N	________________________________
Excessive Thirst	Y	N	________________________________
Fainting Spells/Dizziness	Y	N	________________________________
Frequent Cough	Y	N	________________________________
Frequent Diarrhea	Y	N	________________________________
Frequent Headaches	Y	N	________________________________
Genital Herpes	Y	N	________________________________
Glaucoma	Y	N	________________________________
Hay Fever	Y	N	________________________________
Heart Attack/Failure	Y	N	________________________________
Heart Murmur	Y	N	________________________________
Heart Pace Maker	Y	N	________________________________
Heart Trouble/Disease	Y	N	________________________________
Hemophilia	Y	N	________________________________
Hepatitis A	Y	N	________________________________
Hepatitis B or C	Y	N	________________________________
Herpes	Y	N	________________________________
High Blood Pressure	Y	N	________________________________
Hives or Rash	Y	N	________________________________
Hypoglycemia	Y	N	________________________________
Irregular Heartbeat	Y	N	________________________________
Kidney Problems	Y	N	________________________________
Leukemia	Y	N	________________________________
Liver Disease	Y	N	________________________________
Low Blood Pressure	Y	N	________________________________
Lung Disease	Y	N	________________________________
Mitral Valve Prolapse	Y	N	________________________________
Pain in Jaw Joints	Y	N	________________________________
Parathyroid Disease	Y	N	________________________________

Psychiatric Care	Y	N	________________________________
Radiation Treatments	Y	N	________________________________
Recent Weight Loss	Y	N	________________________________
Renal Dialysis	Y	N	________________________________
Rheumatic Fever	Y	N	________________________________
Rheumatism	Y	N	________________________________
Scarlet Fever	Y	N	________________________________
Shingles	Y	N	________________________________
Sickle Cell Disease	Y	N	________________________________
Sinus Trouble	Y	N	________________________________
Spina Bifida	Y	N	________________________________
Stomach/Intestinal Disease	Y	N	________________________________
Tonsillitis	Y	N	________________________________
Tuberculosis	Y	N	________________________________
Tumors or Growths	Y	N	________________________________
Ulcers	Y	N	________________________________
Venereal Disease	Y	N	________________________________
Yellow Jaundice	Y	N	________________________________

Have you ever had any serious illness not listed above? Y N

If yes, please explain:

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Comments:

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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: ________________