



# 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.

## PATIENT INFORMATION

- |  | Y                        | N                        |   |
|--|--------------------------|--------------------------|---|
| 1. Are you under a physician's care now?                     | <input type="checkbox"/> | <input type="checkbox"/> | <i>If yes, please explain:</i><br>_____<br>_____<br>_____ |
| 2. Have you ever been hospitalized or had a major operation? | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 3. Have you ever had a serious head or neck injury?          | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 4. Are you taking any medications, pills, or drugs?          | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 5. Do you take, or have you taken, Phen-Fen or Redux?        | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 6. Are you on a special diet?                                | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 7. Do you use tobacco?                                       | <input type="checkbox"/> | <input type="checkbox"/> |   |
| 8. Do you use controlled substances?                         | <input type="checkbox"/> | <input type="checkbox"/> |   |

## Women

- |  | Y                        | N                        |
|--|--------------------------|--------------------------|
| Are you Pregnant/Trying to get pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you Nursing?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking oral contraceptives?      | <input type="checkbox"/> | <input type="checkbox"/> |

## Allergies

- |                                  |   |  |                                  |
|----------------------------------|---|--|----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin     | <input type="checkbox"/> Codeine           | <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> Metal   | <input type="checkbox"/> Latex          | <input type="checkbox"/> Local Anesthetics |                                  |
| <input type="checkbox"/> Other   | <i>If yes, please explain:</i><br>_____ |  |                                  |

## PAST CONDITIONS

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? *Check all that apply:*

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

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 (*patient or parent/guardian*) \_\_\_\_\_ DATE \_\_\_\_\_