

**Medical History**

Patient Name: \_\_\_\_\_

Your overall health as well as any medications which you take could have an important interrelationship with the dental care you receive. **PLEASE** answer each of the following questions completely. Thank You!

- Have you had any difficulty with previous visits to the dentist or physicians? \_\_\_\_\_
- Are you under a physician's care now? YES \_\_\_ NO \_\_\_ \_\_\_\_\_
- Have you been hospitalized or had a major operation? YES \_\_\_ NO \_\_\_ \_\_\_\_\_
- Have you had a serious head or neck injury? YES \_\_\_ NO \_\_\_ \_\_\_\_\_
- Please list ANY medications, INCLUDING over the counter that you are taking?  
\_\_\_\_\_

- Have you ever taken Phen-Fen or Redux? YES \_\_\_ NO \_\_\_ If so how long? \_\_\_\_\_
- Are you on a special diet? YES \_\_\_ NO \_\_\_ If so for what purpose? \_\_\_\_\_
- Do you use tobacco? YES \_\_\_ NO \_\_\_ if so for how long? \_\_\_\_\_
- Do you use controlled substances? YES \_\_\_ NO \_\_\_ If yes what substance and purpose? \_\_\_\_\_
- WOMEN:** are you pregnant/trying to get? YES \_\_\_ NO \_\_\_ If pregnant how many weeks? \_\_\_\_\_
- Are you **ALLERGIC** to any of the following? Aspirin \_\_\_ Penicillin \_\_\_ Codeine \_\_\_ Acrylic \_\_\_ Metal \_\_\_  
Latex \_\_\_ Local Anesthetics \_\_\_ Other Antibiotics (Please name) \_\_\_\_\_
- Any Other Allergies: \_\_\_\_\_

- Do you have currently have or a history of the following?
- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Aids/HIV Positive         | <input type="checkbox"/> Cortisone Medicines       | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Recent 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 Heart Beat   | <input type="checkbox"/> Spina Bifida        |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Stomach 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 Problems        | <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 Pacemaker*          | <input type="checkbox"/> Radiation Treatment    | <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 you have please list: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

\*Condition may require Pre-medication

To the best of 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 \_\_\_\_\_

I understand that my insurance is an agreement between myself and my insurance company. I understand that I am responsible for the balance regardless of my insurance.

Signature \_\_\_\_\_  
(For office use) Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_