

Medical History

Name: _____

Birth Date: _____ / _____ / _____
Year Month 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 use recreational drugs? **Yes** **No** If Yes, please explain: _____
- Are you on a special diet? **Yes** **No** If Yes, please explain: _____
- Do you use tobacco? **Yes** **No** If Yes, how many per day: _____
- Has your Physician ever said you need to take antibiotics prior to a dental appointment? **Yes** **No** If Yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to or had an unusual reaction 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?

<input type="checkbox"/> AIDS/HIV Positive <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Artificial Joint <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Breathing Problem <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> MRSA <input type="checkbox"/> Have you ever any serious illness not listed above?	<input type="checkbox"/> Chest Pains <input type="checkbox"/> Cold Sores/Fever Blisters <input type="checkbox"/> Congenital Heart Disorder <input type="checkbox"/> Convulsions <input type="checkbox"/> Cortisone Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Easily Winded <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Fainting Spells/Dizziness <input type="checkbox"/> Frequent Cough <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Heart Attack/Failure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Pace Maker <input type="checkbox"/> Heart Trouble/Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hives or Rash <input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pain in Jaw Joints <input type="checkbox"/> Parathyroid Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatments <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism	<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shingles <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Stomach/Intestinal <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Limbs <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors or Growths <input type="checkbox"/> Ulcers/Gastric/Reflux <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Yellow Jaundice
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If Yes, please explain: _____

Can we do anything to make your dental treatment more comfortable: _____

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: _____