MEDICAL HISTORY
PATIENT NAME_____
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

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Have you ever been hospitalized or had a major operation? YES NO_____
Have you ever had a serious head or neck injury? YES NO
Do you take, or have you taken, Phen-Fen or Redux? YES NO
Do you use tobacco? YES NO
Are you on a special diet? YES NO Do you use controlled substances? YES NO
Are you pregnant? YES NO N/A Do you take oral contraceptives? YES NO
Are you allergic to any of the following? (please circle)
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other_____
Do you have, or have had, any of the following? (Please circle)
AIDS/HIV Positive Chest Pains Frequent Headaches Irregular Heartbeat Scarlet Fever
Alzheimer's Disease Cold Sores/Fever Blisters Genital Herpes Kidney Problems Shingles
Anaphylaxis Congenital Heart Disorder Glaucoma Leukemia Sickle Cell Disease
Anemia Convulsions Hay Fever Liver Disease Sinus Trouble
Angina Cortisone Medicine Heart Attack/Failure Low Blood Pressure Spina Bifida
Arthritis/Gout Diabetes Heart Murmur Lung Disease Stomach/Intestinal Disease
Artificial Heart Valve Drug Addiction Heart Pace Maker Mitral Valve Prolapse Stroke
Artificial Joint Easily Winded Heart Trouble/Disease Pain in Jaw Joints Swelling of Limbs
Asthma Emphysema Hemophilia Parathyroid Disease Thyroid Disease
Blood Disease Epilepsy or Seizures Hepatitis A Psychiatric Care Tonsillitis
Blood Transfusion Excessive Bleeding Hepatitis B or C Radiation Treatments Tuberculosis
Breathing Problem Excessive Thirst Herpes Recent Weight Loss Tumors or Growths

Bruise Easily Fainting Spells/Dizziness High Blood Pressure Renal Dialysis Ulcers
Cancer Frequent Cough Hives or Rash Rheumatic Fever Venereal Disease
Chemotherapy Frequent Diarrhea Hypoglycemia
Rheumatism Yellow Jaundice
Have you ever had any serious illness not listed above? YES NO N/A

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List of medications and additional 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_____
___ Date_____