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 questions.

Do you have any artificial joints?	Yes/No	_____
Are you under a physician's care now?	Yes/No	If yes, explain:_____
Have you been hospitalized or had a major operation?	Yes/No	If yes, explain:_____
Have you ever had a serious head or neck injury?	Yes/No	If yes, explain:_____
Are you taking any prescription/over-the-counter medications?	Yes/No	If yes, please list on other side.
Do you take, or have you taken, Phen-Fen or Redux?	Yes/No	
Are you on a special diet?	Yes/No	_____
Do you use tobacco?	Yes/No	_____
Do you drink alcohol?	Yes/No	_____
Do you use controlled substances?	Yes/No	_____

Women: Are you

Pregnant/Trying to get pregnant? Yes/No Taking oral contraceptives? Yes/No Nursing? Yes/No

Are you allergic to any of the following? (circle all that apply)

Aspirin Penicillin/Antibiotics Codeine Acrylic Metal Latex Local Anesthetics

Other, please explain:_____

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

AIDS/HIV Positive	Yes/No	Frequent Diarrhea	Yes/No	Rheumatism	Yes/No
Alzheimer's Disease	Yes/No	Frequent Headaches	Yes/No	Scarlet Fever	Yes/No
Anaphylaxis	Yes/No	Glaucoma	Yes/No	Shingles	Yes/No
Anemia	Yes/No	Hay Fever	Yes/No	Sickle Cell Disease	Yes/No
Angina	Yes/No	Heart Attack/Failure	Yes/No	Sinus Trouble	Yes/No
Arthritis/Gout	Yes/No	Heart Murmur	Yes/No	Spina Bifida	Yes/No
Artificial Heart Valve	Yes/No	Heart Pace Maker	Yes/No	Stomach/Intestinal Disease	Yes/No
Artificial Joint	Yes/No	Heart Trouble/Disease	Yes/No	Stroke	Yes/No
Asthma	Yes/No	Hemophilia	Yes/No	Swelling of Limbs	Yes/No
Blood Disease	Yes/No	Hepatitis A	Yes/No	Thyroid Disease	Yes/No
Blood Transfusion	Yes/No	Hepatitis B or C	Yes/No	Tonsillitis	Yes/No
Breathing Problem	Yes/No	Herpes	Yes/No	Tuberculosis	Yes/No
Bruise Easily	Yes/No	High Blood Pressure	Yes/No	Tumors or Growths	Yes/No
Cancer	Yes/No	Hives or Rash	Yes/No	Ulcers	Yes/No
Chemotherapy	Yes/No	Hypoglycemia	Yes/No	Yellow Jaundice	Yes/No
Chest Pains	Yes/No	Irregular Heartbeat	Yes/No		
Cold Sores/Fever Blisters	Yes/No	Kidney Problems	Yes/No		
Congenital Heart Disorder	Yes/No	Leukemia	Yes/No		
Convulsions	Yes/No	Liver Disease	Yes/No	Have you ever had any serious illness not listed above?	Yes/No
Cortisone Medicine	Yes/No	Low Blood Pressure	Yes/No	If yes, please explain:_____	
Diabetes	Yes/No	Lung Disease	Yes/No	_____	
Drug Addiction	Yes/No	Mitral Valve Prolapse	Yes/No	_____	
Easily Winded	Yes/No	Pain in Jaw Joints	Yes/No	_____	
Emphysema	Yes/No	Parathyroid Disease	Yes/No	_____	
Epilepsy	Yes/No	Psychiatric Care	Yes/No	_____	
Excessive Bleeding	Yes/No	Radiation Treatments	Yes/No	_____	
Excessive Thirst	Yes/No	Recent Weight Loss/Gain	Yes/No	_____	
Fainting Spells, Dizziness	Yes/No	Renal Dialysis	Yes/No	_____	
Frequent Cough	Yes/No	Rheumatic Fever	Yes/No	_____	