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Patient Medical History Form

Please enter your name here (first, last)

Today's Date (00/00/0000)

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 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 use controlled substances?	Yes	No	

Women: Are you

Pregnant/Trying to get pregnant? ☐ Taking oral contraceptive? ☐ Nursing? ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐

Other If checked, please explain

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Renal Dialysis	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Rheumatic Fever	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Rheumatism	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Scarlet Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Shingles	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	Hives or Rash	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hypoglycemia	Yes No	Sinus Trouble	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Irregular Heartbeat	Yes No	Spina Bifida	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Kidney Problems	Yes No	StomachlIntestinal Dise	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Leukemia	Yes No	Stroke	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Lung Disease	Yes No	Tonsillitis	Yes No
Cancer	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Congenital Heart Disorder	Yes No	Heart Pace Maker	Yes No	Radiation Treatments	Yes No	Yellow Jaundice	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Recent Weight Loss	Yes No		

Reset this portion

Have you ever had any serious illness not listed above? ☐ **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 OF PATIENT, PARENT, or GUARDIAN DATE

Email Form