# Medical History

*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 irrealationship with the dentistry you will receive. Thank you for answering the following questions.*

Are you under physician's care now? [ ] Y [ ] N If yes, please list:_____

Have you ever been hospitalized or had a major operation? [ ] Y [ ] N If yes, please list:_____

_____

Have you ever had a serious head or neck injury? [ ] Y [ ] N If yes, please list:_____

Are you taking any medications? [ ] Y [ ] N If yes, please list:_____

_____

Are you taking any medications for osteoporosis? [ ] Y [ ] N If yes, please list:_____

Do you take, or have you taken, Phen-Fen or Redux? [ ] Y [ ] N

Are you on a special diet? [ ] Y [ ] N

Do you use tobacco? [ ] Y [ ] N

Do you use controlled substances? [ ] Y [ ] N

Are you taking any blood thinners or Aspirin? [ ] Y [ ] N

Women: Are you…

[ ] Pregnant/Trying to get Pregnant

[ ] Taking oral contraceptives

[ ] Nursing

Are you allergic to any of the following? [ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics [ ] Sulfa OTHER:_____

Do you have or had any of the following?

- o AIDS/HIV Positive
- o Alzheimer's
- o Anaphylaxis
- o Anemia
- o Angina
- o Arthritis/Gout
- o Artificial Heart Valve
- o Artificial Joint
- o Asthma
- o Blood Disease
- o Blood Transfusion
- o Breathing Problem
- o Bruises Easily
- o Cancer
- o Chemotherapy
- o Chest Pains
- o Cold Sores/Fever Blisters
- o Congenital Heart Disorder
- o Convulsions
- o Cortisone Medicine
- o Diabetes
- o Drug Addiction
- o Easily Winded
- o Emphysema
- o Epilepsy/Seizures
- o Excessive Bleeding
- o Excessive Thirst
- o Fainting Spells/Dizziness
- o Frequent Cough
- o Frequent Diarrhea
- o Frequent Headaches
- o Genital Herpes
- o Glaucoma
- o Hay Fever
- o Heart Attack/Failure
- o Heart Murmur
- o Heart Pace Maker
- o Heart Trouble/Disease
- o Hemophilia
- o Hepatitis A
- o Hepatitis B or C
- o Herpes
- o High Blood Pressure
- o Hives or Rash
- o Hypoglycemia
- o Irregular Heartbeat
- o Kidney Problems
- o Leukemia
- o Liver Disease
- o Low Blood Pressure
- o Lung Disease
- o Mitral Valve Prolapse
- o Pain in Jaw Joints
- o Parathyroid Disease
- o Psychiatric Treatments
- o Recent Weight Loss
- o Renal Dialysis
- o Rheumatic Fever
- o Rheumatism
- o Scarlet Fever
- o Shingles
- o Sickle Cell Disease
- o Sinus Trouble
- o Spinal Bifida
- o Stomach/Intestinal Disease
- o Stroke
- o Swelling of Limbs
- o Thyroid Disease
- o Tonsillitis
- o Tuberculosis
- o Tumors or Growths
- o Ulcers
- o Venereal Disease
- o Yellow Jaundice

Have you had any serious illnesses not listed above? If yes please explain:_____

_____

*To the best of my knowledge, the questions on this form have been accuratley 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 chnages in medical status.*

*Signature of Patient, Parent, or Guardian:*_____ *Date:*_____