MEDICAL HISTORY

Although dental personnel primary 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** ______________________
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** ______________________
Notes:____

Woman: Are you
Pregnant/ Trying to get pregnant? Taking oral contraceptives? Yes/No Nursing? Yes/No

Are you allergic to any of the following? Please circle.
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other : ______________________

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD, ANY OF THE FOLLOWING?

AIDS/HIV POSITIVE	**Cortisone Medicine**	Heart Trouble/Disease	Rheumatic Fever
Alzheimer's Disease	**Diabetes**	Hemophilia	Scarlet Fever
Anaphylaxis	**Drug Addiction**	Hepatitis A	Shingles
Anemia	**Easily Winded**	Hepatitis B or C	Sickle Cell Disease
Arthritis/Gout	**Emphysema**	Herpes	Sinus Trouble
Artificial Heart Valve	**Epilepsy or Seizures**	High Blood Pressure	Spina Bifida
Artificial Joint	**Breathing Difficulty**	Hives or Rash	Stomach/intestinal
Asthma	**Excessive bleeding**	Hypoglycemia	Disease
Blood Disease	**Excessive thirst**	Irregular Heartbeat	Stroke
Blood transfusion	**Fainting Spells/Dizziness**	Kidney Problem	Sulfa
Breathing Problem	**Frequent Cough**	Leukemia	Swelling of Limbs
Bruise Easily	**Frequent Diarrhea**	Liver Disease	Thyroid Disease
Cancer	**Frequent Headaches**	Mitral Valve Prolapse	Tonsillitis
Chemotherapy	**Genital Herpes**	Pain in Jaw Joint	Tuberculosis tumors or
Chest Pain	**Glaucoma**	Parathyroid Disease	Growths
Cold Sores/Fever blister	**Hay Fever**	Psychiatric Care	Ulcers
Congenital Heart Disorder	**Heart Attack/Failure**	Radiation Treatments	Venereal Disease
Convulsion	**Heart Murmur**	Recent Weight Loss	Yellow Jaundice
	Heart Pace Maker	Renal Fever	

Have you ever had any serious illness not listed above? Yes / No ______________________

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 ______________