

Medical History

Although our Dental Team primarily treats areas in and around your mouth the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible, Thank You!

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: _____

Have you ever taken, Phen-Fen, Redux, Fosamax? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Please list any medications, pills, or drugs you are taking: _____

Women:

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

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

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____