Medical History

Patient Name: _____ Birth Date: _____

Although our Dental Team primarily treats areas in and around your mouth the health of your entire body can influence treat ment 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	☐ Epilepy or Siezures	☐ 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	☐ Tonsilitis	_____
☐ 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 patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or omissions 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: _____