## **MEDICAL HISTORY**

PATIENT NAME	Birth Date

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? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Are you on a special diet?					No	If yes, please explain: _					
					No	If yes, please explain: _					
					No						
					No	If ves, please explain:					
					No						-
					No						
Do you use tobacco?					No						
Do you use controlled substances?					No						
	Do	you ne	eed to pre-medicate?	Yes	No	If yes, please explain:					
Women: Are you Preg					No	Taking oral contrace	otives?	Yes	No Nursing?	Yes	No
Are you allergic to any		JIIOWIN	•								
Aspirin Pe	enicillin		Codeine Ad	crylic		Metal Latex		Local	Anesthetics		
Other If yes, pleas	se expla	in:									
Do you have, or have y	ou had,	any of	the following?								
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	b Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No		Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	<ul> <li>Hepatitis B or C</li> </ul>	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	Nc		Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	<ul> <li>High Blood Pressure</li> </ul>	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	<ul> <li>Hives or Rash</li> </ul>	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	b Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	<ul> <li>Irregular Heartbeat</li> </ul>	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	<ul> <li>Kidney Problems</li> </ul>	Yes	No	Stomach/Intestinal Disease	e Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	b Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	b Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	b Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	b 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	<ul> <li>Psychiatric Care</li> </ul>	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			
Have you ever had any	serious	illnoss	not listed above?	Yes	No	lf 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 \_\_\_\_\_\_ DATE \_\_\_\_\_\_