

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_

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.

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy of Choice \_\_\_\_\_ Phone \_\_\_\_\_

Are you under a physician's care now?  Yes  No  Explain \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No  Explain \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No  Explain \_\_\_\_\_

Have you ever had radiation treatment? When? \_\_\_\_\_

Do you use alcohol?  Yes  No  How Much \_\_\_\_\_

Do you use tobacco?  Yes  No  Explain \_\_\_\_\_

Do you use controlled substances?  Yes  No  Explain \_\_\_\_\_

Are you on a special diet?  Yes  No  Explain \_\_\_\_\_

Do you take, or have you taken, Phen-Fen, Redux or diet pills?  Yes  No  Explain \_\_\_\_\_

Are you taking any medications, pills, drugs, or herbal supplement?  Yes  No  Explain \_\_\_\_\_

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other

Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Have you ever been told you **need to Pre Medicate** prior to dental appointment?  Yes  No  Explain \_\_\_\_\_

Check box (es) if you have or have had any of the following

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

Any other illness not listed above: \_\_\_\_\_

Medications: \_\_\_\_\_

Have you ever had any serious illness not listed above  Yes  No  N/A \_\_\_\_\_

Comments: \_\_\_\_\_

\*Condition may require medication N/A - Not answered by patient

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.

DR.'S SIGNATURE \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_