

**MEDICAL HISTORY**

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

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.

**PLEASE CIRCLE YES or NO TO THE FOLLOWING QUESTIONS.**

Have you ever been hospitalized? Yes No If yes, please explain: \_\_\_\_\_

Have you had a major operation? Yes No If yes, please explain: \_\_\_\_\_

Are you under a physician's care now? Yes No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? Yes No If yes, please explain: \_\_\_\_\_

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

**Women Only:**

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

**Are you allergic to any of the following?**

- Aspirin    Penicillin    Codeine    Local Anesthetics    Barbiturates (sleeping pills)    Iodine
- Acrylic    Metal    Latex    Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? **CIRCLE YES or NO**

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	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/Allergies	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/ Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatment	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	Contact Lenses	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: \_\_\_\_\_

**MEDICATIONS** List all medications you are currently taking including non-prescription medicine.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DENTAL HISTORY** Reason for today's visit: \_\_\_\_\_ Former Dentist: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental X-rays: \_\_\_\_\_ Brush and floss: \_\_\_\_\_ x day

Do your gums bleed or bad breath? Yes No Do you smoke or chew? Yes No

Does food catch between your teeth? Yes No Do you have any loose teeth? Yes No

Do you have popping/discomfort in the jaw joint? Yes No Do you grind your teeth? Yes No

Do you want to keep remaining teeth? Yes No Do you like your smile? 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 \_\_\_\_\_  
PATIENT, PARENT, or GUARDIAN

DATE \_\_\_\_\_

DOCTOR SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_