# Medical History

Physician's Name _____ Date of Last Visit _____

Physician's Address _____ Physician's Phone _____

Pharmacy and Address _____ Pharmacy Phone _____

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? | ☐ 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: _____ |
| Are you taking any medications, pills, or drugs? | ☐ Yes | ☐ No | If yes, please explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | ☐ Yes | ☐ No | If yes, please explain: _____ |
| 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 | |
| Do you wear contact lenses? | ☐ Yes | ☐ No | |

Are you allergic to or have you had any reactions to the following?

☐ Local anesthetics (e.g., novacaine) ☐ Barbiturates ☐ Aspirin ☐ Codeine ☐ Acrylic

☐ Penicillin or any other antibiotics ☐ Sedatives ☐ Any metals (e.g., nickel, mercury, etc.) _____

☐ Sulfa drugs ☐ Iodine ☐ Latex rubber

☐ Other (please list) _____

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

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If 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 _____