MEDICAL HISTORY

Although dental personnel primary 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, explain: _____
Have you had 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**
Do you use tobacco? ☐**Yes** /☐**No**
Do you use controlled substances? ☐ **Yes** /☐**No**
Notes:_____ _

Woman: Are you
☐Pregnant /☐Trying to get pregnant? Taking oral contraceptives? ☐Yes / ☐ No Nursing?☐Yes /☐No

Are you allergic to any of the following? Please check box.
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics
Other : _____

PLEASE CHECK BOX IF YOU HAVE OR HAVE HAD, ANY OF THE FOLLOWING?

AIDS/HIV POSITIVE ☐	**Cortisone Medicine** ☐	Heart Trouble/Disease ☐	Rheumatic Fever ☐
Alzheimer's Disease ☐	**Diabetes** ☐	Hemophilia ☐	Scarlet Fever ☐
Anaphylaxis ☐	**Drug Addiction** ☐	Hepatitis A, B or C ☐	Shingles ☐
Anemia ☐	**Easily Winded** ☐	Herpes ☐	Sickle Cell Disease ☐
Arthritis/Gout ☐	**Emphysema** ☐	High Blood Pressure ☐	Sinus Trouble ☐
Artificial Heart Valve ☐	**Epilepsy or Seizures** ☐	Hives or Rash ☐	Spina Bifida ☐
Artificial Joint ☐	**Breathing Difficulty** ☐	Hypoglycemia ☐	Stomach/intestinal ☐
Asthma ☐	**Excessive bleeding** ☐	Irregular Heartbeat ☐	Disease Stroke ☐
Blood Disease ☐	**Excessive thirst** ☐	Kidney Problem ☐	Sulfa ☐
Blood transfusion ☐	**Fainting Spells/Dizziness** ☐	Leukemia ☐	Swelling of Limbs ☐
Breathing Problem ☐	**Frequent Cough Frequent** ☐	Liver Disease ☐	Thyroid Disease ☐
Bruise Easily ☐	**Diarrhea Frequent** ☐	Mitral Valve Prolapse ☐	Tonsillitis ☐
Cancer ☐	**Headaches Genital Herpes** ☐	Pain in Jaw Joint ☐	Tuberculosis ☐
Chemotherapy ☐	**Glaucoma** ☐	Parathyroid Disease ☐	Tumors or Growths ☐
Chest Pain ☐	**Hay Fever** ☐	Psychiatric Care ☐	Ulcers ☐
Cold Sores/Fever blister ☐	**Heart Attack/Failure Heart** ☐	Radiation Treatments ☐	Venereal Disease ☐
Congenital Heart Disorder ☐	**Murmur** ☐	Recent Weight Loss ☐	Yellow Jaundice ☐
Convulsion ☐	**Heart Pace Maker** ☐	Renal Fever ☐	

Have you ever had any serious illness not listed above? ☐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. <u>It is my responsibility to inform the dental office of any changes in medical status</u>

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE _____