

MEDICAL HISTORY

NAME _____

DATE OF BIRTH _____

PHONE _____

ADDRESS _____

SOCIAL SECURITY NUMBER _____

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

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

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

Are you taking any medications, pills, or drugs? Yes No

Do you use tobacco? Yes No

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

Are you allergic to any of the following?

Aspirin Penicillin Codeine Latex Local Anesthetics Other _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arrhythmia/Irreg. Heartbeat | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Excessive Bleeding | Other: _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting Spells/Dizziness | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Pacemaker | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Trouble/Disease | |

Medications You Are Currently Taking

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 my medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____