Medical History

Although dental personnel primarily treats the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications you may 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 (besides general) now? ❑ Yes ❑ No If yes, please explain_____

Have you been hospitalized or had a major operation within the last five (5) years? ❑ 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_____

Have you been asked by your doctor to pre-medicate? ❑ Yes ❑ No If yes, please explain_____

Are you on a special diet? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substance? ❑ Yes ❑ No

Women: Are you…

❑ Pregnant/Trying to get pregnant? (circle one)

❑ Taking oral contraceptives? ❑ Nursing

Are you allergic to the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Sulfa ❑ Other_____

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

❑ AIDS/HIV Positive	❑ Chest Pains	❑ Heart Pace Maker	❑ Psychiatric Care
❑ Alzheimer's Disease	❑ Cold Sores/Fever Blisters	❑ Heart Trouble/Disease	❑ Radiation Treatment
❑ Anaphylaxis	❑ Congenital Heart Disorder	❑ Hemophilia	❑ Rheumatic Fever
❑ Angina	❑ Diabetes	❑ Hepatitis A	❑ Seizures
❑ Arthritis/Gout	❑ Drug Addiction	❑ Hepatitis B or C	❑ Sinus Trouble
❑ Artificial Heart Valve	❑ Emphysema	❑ High Blood Pressure	❑ Stroke
❑ Artificial Joint	❑ Epilepsy	❑ Hives or Rash	❑ Thyroid Disease
❑ Asthma	❑ Excessive Bleeding	❑ Kidney Problems	❑ Tuberculosis
❑ Blood Disease	❑ Fainting Spells/Dizziness	❑ Leukemia	❑ Tumors or Growths
❑ Blood Transfusion	❑ Frequent Headaches	❑ Liver Disease	❑ Ulcers
❑ Breathing Problem	❑ Genital Herpes	❑ Low Blood Pressure	❑ Yellow Jaundice
❑ Bruise Easily	❑ Glaucoma	❑ Lung Disease	
❑ Cancer	❑ Heart Attack/Failure	❑ Mitral Valve Prolapse	
❑ Chemotherapy	❑ Heart Murmur	❑ Pain in Jaw Joints	

Have you ever has 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 medical history information can be dangerous to the patient's health. It is my responsibility to inform Family Dental Center of any changes in the patient's medical status.

Print Name _____ Date _____

Signature _____