



MEDICAL HISTORY

Patient Name _____ Chart # _____

Date _____ Date of Birth _____ How did you hear about us? _____

Emergency Contact: Name _____ Phone Number _____

When was your last dental exam _____ Dentist's Name _____

Why have you come to see us today? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your 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 been involved in 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 If yes, please explain: _____

Do you use controlled substances? Yes No If yes, please explain: _____

Have you received or are you currently receiving any of the following drugs: Fosamax, Actonel, Boniva, Aredia or Zometa? Yes No If yes, please explain: _____

Do you require a PreMed? Yes No If yes, please explain: _____

Women: Are you...

Pregnant / Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Other, please explain: _____

Comments: _____

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

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

Do you have a guardian? YES NO Relationship _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ UPDATE _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ UPDATE _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ UPDATE _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ UPDATE _____