Medical History

Today's Date:_____

Patient

First Name:_____ Last Name:_____ Middle Initial:_____

Date of Birth:_____

Are you under a physician's care?	○ Yes	○ No	_____
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	_____
Are you taking any medications, pills or drugs?	○ Yes	○ No	_____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	_____
Do you smoke or use tobacco?	○ Yes	○ No	_____
Do you use controlled substance?	○ Yes	○ No	_____

Women: Are you

☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

☐ Other _____

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

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

Comments:_____

_____

To the best of my knowledge, the questions on this form have been 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:_____