

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____

Although dental professionals 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 a profound relationship with the dentistry you will receive. Thank you for answering the following questions.

Email Address: _____

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 has 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, Pen-Fen or Redux? __ Yes __ No If yes, please explain: _____

Are you on a special diet? __ Yes __ No If yes, please explain _____

Do use tobacco? __ Yes __ No

Do you use controlled substance? __ Yes __ No

Are you allergic to any of the following?

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

Other Please list: _____

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

<input type="checkbox"/> AIDS/HIV POSITIVE	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Anemia	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Angina	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shingles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Swelling Of Limbs
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Gastrointestinal disease/ reflux	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer/ Chemotherapy	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tonsilitis
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cold Sores/Fever Blister	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pain in jaw joints	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Parathyroid Disease	
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care	

Have you ever had any serious illness not listed above? __ Yes __ No If Yes, please explain: _____

To the best of my knowledge, the questions on this form have been answered accurately. 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.

Patient Signature: _____ Date: _____

DOCTORS' S COMMENTS: _____

Doctor's Signature: _____ Date: _____