MEDICAL HISTORY

PATIENT NAME	Birth Date
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 take, or have you taken, Phen-Fen or Redux? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Women: Are you	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Nursing?	
Aspirin Penicillin Codeine Acrylic	Metal Latex Local Anesthetics
Other If yes, please explain: Do you have, or have you had, any of the following? AIDS/HIV Positive	o Hemophilia
Alzheimer's Disease Yes No Diabetes Yes No Anaphylaxis Yes No Drug Addiction Yes No Anemia Yes No Easily Winded Yes No Arthritis/Gout Yes No Emphysema Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Asthma Yes No Excessive Thirst Yes No Asthma Yes No Fainting Spells/Dizziness Yes No Blood Disease Yes No Frequent Cough Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No Breathing Problem Yes No Frequent Diarrhea Yes No Bruise Easily Yes No Genital Herpes Yes No Cancer Yes No Glaucoma Yes No Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Congenital Heart Disorder Yes No Convulsions Yes No Heart Attack/Failure Yes No Convulsions Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Have you ever had any serious illness not listed above? Yes No No Prequent Poisorder Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No No Prequent Poisorder Yes No Heart Trouble/Disease Yes No No Heart Trouble/Disease Yes No No Heart Trouble/Disease Yes No No Prequent Poisorder Yes No Heart Trouble/Disease Yes No No No Heart Trouble/Disease Yes No	Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No Hives or Rash Yes No Hypoglycemia Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Leukemia Yes No Liver Disease Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Mitral Valve Prolapse Yes No Manada Yes No Merarthyroid Disease Yes No Merarthyroid Diseas
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.	
SIGNATURE OF PATIENT, PARENT, or GUARDIAN	DATE