MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Address _____ Best Contact Ph# _____

_____ Email address: _____

How did you hear about Us? Commercial Facebook Flyer Special Aid Other:_____

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. Circle **ONLY** what applies.

Are you under a physician's care now? Yes No Dr's Name/ for what: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Please List **ALL Medication** you are currently taking: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances Or Under Pain management? Yes No Dr.'s Name/facility: _____

Have you ever needed to be pre-medicate? Yes No If yes, please explain: _____

[**Women**: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No]

** Are you **ALLERGIC** to any of the following? Aspirin Penicillin Codeine Acrylic Metal Local Anesthetics

Sulfur drugs Latex Other: Please List: _____

Do you have, or have you had, any of the following? MARK **ONLY** THAT APPLIES

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

Have you ever had any serious illness not listed above? If So please explain:_____

Other 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.

PATIENT/GUARDIAN SIGNATURE DATE