



MEDICAL HISTORY

Patient Name _____ Birth Date _____
 Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Your medical history is very important to us. Please be as thorough as possible while completing this form as treatment may have to be catered to your health history or medication use. Thank you for answering the following questions. Please circle answers.

Are you under the care of a physician now? Y N If yes, please explain _____

Have you been hospitalized or had a major operation within the past 10 years? Y N If yes, please explain: _____

Are you taking any medications, pills, or drugs? Y N Please list medications: _____

Have you ever taken Phen-Fen or Redux? Y N _____

Are you on a special diet? Y N _____

Do you use tobacco? Y N _____

Do you use controlled substances? Y N _____

Women: Are you: Pregnant/trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Are you allergic to any of the following?

Latex Penicillin Latex Codeine Acrylic Metals Local Anesthetics

Other If other, please explain: _____

Do you have or have you had any of the following (please circle or highlight):

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

Have you ever had any serious illness not listed above? Y N If yes, please explain: _____

Additional 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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian: _____

Date: _____