

## MEDICAL HISTORY FORM

**Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

*Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 If Yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  YES /  NO If Yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  YES /  NO If Yes, please explain: \_\_\_\_\_

Are you taking any medication, pills, or drugs?  YES /  NO If Yes, please explain: \_\_\_\_\_

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 controlled substances?  YES /  NO

**Women: Are you...**

Pregnant/trying to get pregnant?  YES /  NO

Nursing?  YES /  NO

Taking oral contraceptives?  YES /  NO

**Are you allergic to any of the following?**

Aspirin       Penicillin Codeine       Acrylic       Metal       Latex       Local Anaesthetics

Other      If Other, please explain: \_\_\_\_\_

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

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

**Have you ever had any serious illness not listed above?**  YES /  NO If Yes, please explain: \_\_\_\_\_

**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 the medical status.*

**Signature of patient, parent or guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_