SIMCOE FAMILY DENTISTRY

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 bone medication? ☐**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 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?

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

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** _____

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