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.	and the second of the second o
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	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:
Do you use tobacco? Yes No	
Do you use controlled substances? Yes No	
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 Latex Local Anesthetics
Other If yes, please explain:	
Do you have, or have you had, any of the following?	
AIDS/HIV Positive Yes No No Cortisone Medicine Yes No No Alzheimer's Disease Yes No No Diabetes Yes No No Anaphylaxis Yes No No Drug Addiction Yes No No Anemia Yes No Easily Winded Yes No No Anthritis/Gout Yes No Emphysema Yes No No Artificial Heart Valve Yes No Excessive Bleeding Yes No No Artificial Joint Yes No Excessive Thirst Yes No No Asthma Yes No Fainting Spells/Dizziness Yes No No Blood Disease Yes No Frequent Cough Yes No No Breathing Problem Yes No Frequent Diarrhea Yes No No Bruise Easily Yes No Genital Herpes Yes No No Chemotherapy Yes No Hay Fever Yes No No Chest Pains Yes No No Heart Attack/Failure Yes No No	Hepatitis A
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 medical status.	
SIGNATURE OF PATIENT, PARENT, or GUARDIAN	DATE