PATIENT MEDICAL HISTORY

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have, or medications you may be taking, could have an important interrelationship with the dental treatment you will be receiving. Thank you for completing this form accurately.

CURRENT PHYSICIAN NAME_____ **CURRENT PHYSICIAN PHONE NUMBER**_____

CURRENT PHYSICIAN ADDRESS_____ **DATE OF LAST PHYSICAL**_____

	YES	NO
Are you in good health?		
Are you under the care of a physician?		
Have you been hospitalized for any surgical operations or serious illness in the last five years?		
If yes, please explain_____		
Are you taking any medicines, including non-prescription such as vitamins, over-the-counter,herbals?		
Have you ever had a serious neck or head injury?		
Do you take, or have you ever taken Phen-Fen or Redux?		
Do you use tobacco?		
Do you have a special diet?		
If yes, please explain_____		
Do you use controlled substances?		
Are you wearing contact lenses?		

MEDICATIONS

List any medications you are currently taking including over-the-counter medicines, vitamins, herbals:

FOR WOMEN ONLY

	YES	NO
Are you or might you be pregnant?		
Are you nursing?		
Are you taking oral contraceptives?		

ALLERGIES

	YES	NO		YES	NO
Aspirin			Sulfa Drugs		
Penicillin			Local Anesthetics		
Codeine			Acrylic		
Iodine			Metals		
Latex			Other		

Please explain:_____

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

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive			Diabetes			Hepatitis B or C			Recent Weight Loss		
Alzheimer's Disease			Dizziness			Herpes			Renal Dialysis		
Allergies			Drug Addiction			High Blood Pressure			Rheumatic Fever		
Anaphylaxis			Emphysema			High Cholesterol			Rheumatism		
Anemia			Epilepsy or Seizures			Hives or Skin Rash			Scarlet Fever		
Angina			Excessive Bleeding			Hypoglycemia			Shingles		
Arthritis/Gout			Excessive Thirst			Irregular Heartbeat			Shortness of Breath		
Artificial Heart Valve			Fainting Spells			Joint replacement or implants			Sickle Cell Disease		
Asthma			Frequent Diarrhea			Jaundice			Sinus Trouble		
Back Problems			Genital Herpes			Kidney Problems			Sleep Apnea		
Blood disease			Glaucoma			Leukemia			Spina Bifida		
Blood transfusion			Hay Fever			Liver Disease			Stomach Troubles		
Breathing problems			Heart Attack/Failure			Low Blood Pressure			Stroke		
Bruise easily			Heart Murmur			Lung Disease			Swelling of Feet, Ankles, Hands		
Cancer			Heart Pace Maker			Mental Health Disorder			Thyroid Disease		
Chemotherapy			Heart Trouble/Disease			Mitral Valve Prolapse			Tonsillitis		
Cold Sores/Fever Blisters			Heart Angina/Chest Pains			Nervous Disorder			Tuberculosis		
Congenital Heart Disorder			Heart Surgery			Pain in Jaw			Tumors or Growths		
Convulsions			Hemophilia			Parathyroid Disease			Ulcers		
Cortisone Medicine			Hepatitis A			Radiation Treatments			Venereal Disease		

Please list any serious illness not listed above or any additional comments you feel our dental personnel should know about your medical health history:_____

_____

_____

In order to maintain accurate records, paperwork must be filled out annually.

I certify I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand providing incorrect or incomplete information can be dangerous to my (or the patient's) health. I acknowledge it is my responsibility to inform this dental office of any changes in my (or the patient's) medical health history.

SIGNATURE_____ Date _____

Patient, Parent or Guardian

PRINTED NAME _____

Patient, Parent or Guardian