

**PATIENT MEDICAL HISTORY**

**Patient Name**  **Patient SSN**   
**Primary Address**   
**Phone Number**  **Email Address**

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of the entire body. Health problems that you may have or medications you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following services.

Recent History	Yes	No	Explanation – Date of Last Occurrence
Are you under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a major operation?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a serious neck or head injury?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or have you taken Phen-Fen or Redux?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use tobacco or controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Women:</b> Are you pregnant or trying to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Women:</b> Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Women:</b> Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	

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

Aspirin  Penicillin  Codeine  Acrylic   
 Metal  Latex  Local Anesthetics  Other

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

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 Disease <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Leukemia <input type="checkbox"/>	Single 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 Disease <input type="checkbox"/>
Artificial Heart Valve* <input type="checkbox"/>	Drug Addiction <input type="checkbox"/>	Heart Pacemaker* <input type="checkbox"/>	Mitral Valve Prolapse <input type="checkbox"/>	Stroke <input type="checkbox"/>
Artificial Joint* <input type="checkbox"/>	Easily Winded <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Pain in Jaw Joints <input type="checkbox"/>	Swelling of Limbs <input type="checkbox"/>
Asthma <input type="checkbox"/>	Emphysema <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Parathyroid Disease <input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>
Blood Disease <input type="checkbox"/>	Epilepsy or Seizures <input type="checkbox"/>	Hepatitis A <input type="checkbox"/>	Psychiatric Care <input type="checkbox"/>	Tonsillitis <input type="checkbox"/>
Blood Transfusion <input type="checkbox"/>	Excessive Bleeding <input type="checkbox"/>	Hepatitis B or C <input type="checkbox"/>	Radiation Treatments <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
Breathing Problem <input type="checkbox"/>	Excessive Thirst <input type="checkbox"/>	Herpes <input type="checkbox"/>	Recent Weight Loss <input type="checkbox"/>	Tumors <input type="checkbox"/>
Bruise Easily <input type="checkbox"/>	Fainting Spells/Dizziness <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Renal Dialysis <input type="checkbox"/>	Ulcers <input type="checkbox"/>
Cancer <input type="checkbox"/>	Frequent Cough <input type="checkbox"/>	Hives or Rash <input type="checkbox"/>	Rheumatic Fever* <input type="checkbox"/>	Venereal Disease <input type="checkbox"/>
Chemotherapy <input type="checkbox"/>	Frequent Diarrhea <input type="checkbox"/>	Hypoglycemia <input type="checkbox"/>	Rheumatism <input type="checkbox"/>	Yellow Jaundice <input type="checkbox"/>

Have you ever had any serious illness not listed above?  Yes  No

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

\*Condition may require medication

N/A – not answered by patient