MEDICAL HISTORY

PATIENT NAME: ___________________________________ Date: ___________

Health problems that you may have, or medications that you are taking, could have an interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Physician: ____
Address and phone # of Physician ____
____
List of Medications: ____
____
____

Are you allergic to any of the following?
___Latex ___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___ Local Anesthetics
___Other ______________________

Have you ever been hospitalized or had a major operation? Yes No _______________
Have you ever had a serious head or neck injury? Yes No ________________________
Have you ever had any serious illness? Yes No _________________________________
Are you on 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? Nursing? ___Taking oral contraceptives? ____

Have you had: ____Subacute Bacterial Endocarditis ____ Heart Transplant
_____ Artificial Heart Valve ____Congenital Heart Defect (exluding Mitral Valve Prolapse)

Do you have, or had any of the following?

___ AIDS/HIV Positive	___Emphysema	___Hepatitis A
___Anaphylaxis	___Epilepsy or Seizures	___Hepatitis B or C
___Angina	___Excessive Bleeding	___Herpes
___Artificial Joint	___ Excessive Thirst	___High Blood Pressure
___Asthma	___ Fainting Spells/Dizziness	___Irregular Heartbeat
___Cancer	___Frequent Cough	___Kidney Problems
___ Chemotherapy	___Glaucoma	___Leukemia
___Chest Pains	___ Hay Fever	___ Liver Disease
___Cold Sores/Fever Blisters	___Heart Attack/Failure	___Radiation Treatments
___Congenital Heart Disorder	___Heart Pace Maker	___ Renal Dialysis
___ Diabetes	___Hemophilia	___Sinus Trouble
	___Stroke	___Thyroid Disease

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 change in medical status.

____
Signature of PATIENT, PARENT, or GUARDIAN DATE