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.			
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:	
	rou use tobacco? Yes No lled substances? Yes No		
─Women: Are you— Pregnant/Trying to get pregnant?			
Are you allergic to any of the following? Aspirin Penicillin Other If yes, please explain:	Codeine Acrylic	Metal Latex Loc	al Anesthetics
Alzheimer's Disease Yes No D Anaphylaxis Yes No D Anemia Yes No E Angina Yes No E Arthritis/Gout Yes No E Artificial Heart Valve Yes No E Artificial Joint Yes No E Asthma Yes No F Blood Disease Yes No F Blood Transfusion Yes No F Bruise Easily Yes No G Cancer Yes No G Chemotherapy Yes No H Chest Pains Yes No H Cold Sores/Fever Blisters Yes No H	No No No No No No No No	Hepatitis A	Rheumatic Fever Yes No Rheumatism Yes No Scarlet Fever Yes No Shingles Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tuberculosis Yes No Tumors or Growths Yes No Venereal Disease Yes No Venereal Disease Yes No Vellow Jaundice 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