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.			
Have you ever been hospitalized or had Have you ever had a serious I Are you taking any medicati Do you take, or have you taken, F Are you	head or neck injury? Yes No ions, pills, or drugs? Yes No Phen-Fen or Redux? Yes No ou on a special diet? Yes No oo you use tobacco? Yes No	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:	
Do you use controlled substances?			
Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics			
Other If yes, please explain:			
	Cortisone Medicine Yes No Diabetes Yes No Drug Addiction Yes No Easily Winded Yes No Emphysema Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Frequent Headaches Yes No Genital Herpes Yes No Glaucoma Yes No Hay Fever Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Diabetes Yes No N	Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Mitral Valve Prolapse Yes No Parathyroid Disease Yes No Psychiatric Care Yes No Radiation Treatments Yes No	Renal Dialysis Yes No 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 Tonsillitis Yes No Tuberculosis Yes No Tumors or Growths Yes No Venereal Disease Yes No Venereal Disease Yes No Yes No Venereal Disease Yes No Yes No
		ly answered. I understand that providin ttal office of any changes in medical sta	
dangerous to my (or patient's) health.	It is my responsibility to inform the der	ntal office of any changes in medical sta	tus.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE _____