

Medical History Form



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 taking the time to answer the following questions:

- | | | | |
|---|------------------------------|-----------------------------|-------------------------------|
| Are you currently under a physician's care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Are you taking any medications, pills, or drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Do you take, or have you ever taken Phen-Fen or Redux? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Are you on a special diet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Do you use tobacco of any type? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Do you use any recreation drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |

Women:

- | | | | |
|---|------------------------------|-----------------------------|-------------------------------|
| Are you pregnant or trying to get pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Are you taking oral contraceptives? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |
| Are you currently nursing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please explain: _____ |

Are you allergic to any of the following?

- | | | | |
|----------------------------------|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Other _____ |

If yes, please explain: _____

Medical History Form Cont.



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

- | | | | | | |
|---------------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|-----------------------------|
| 1. AIDs/HIV Positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 32. Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Alzheimer's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 33. Heart Pace Maker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Anaphylaxis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 34. Heart Trouble / Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 35. Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Angina | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 36. Hepatitis A, B, or C | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Arthritis / Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 37. Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Artificial Heart Valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 38. High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Artificial Joint | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 39. Hypoglycemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 40. Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Blood Disease / Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 41. Leukemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Breathing Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 42. Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Bruise Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 43. Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 44. Lung Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 45. Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Chest Pains | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 46. Parathyroid Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Cold Sores / Fever Blisters | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 47. Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Congenital Heart Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 48. Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 49. Recent Weight Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Cortisone Injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 50. Renal Dialysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 51. Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Drug Addiction | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 52. Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Easily Winded | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 53. Shingles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 54. Sickle Cell Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Epilepsy or Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 55. Stomach / Intestinal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. Excessing Bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 56. Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. Fainting Spells / Dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 57. Thyroid Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. Frequent Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 58. Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 28. Frequent Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 59. Tumors | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 29. Genital Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 60. Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 30. Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 61. Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 31. Heart Attack / Failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 62. Yellow Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Any serious illnesses not listed above? _____

Notes:

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 my dependent's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date