



**Patient Medical History**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Birth date Primary Care Physician's name

Please help us provide appropriate care for you by describing your medical history below:

- Yes  No Are you having dental pain or discomfort now?
- Yes  No Have there been changes in your general health in the last two years?
- Yes  No Have you ever been informed of the need for premedication prior to dental treatment?
- Yes  No Are you under a physician's care now?
- Yes  No Have you even been hospitalized or had a major operation?
- Yes  No Have you ever had a serious head or neck injury?
- Yes  No Do you take, or have you taken, Phen-Fen or Redux?
- Yes  No Are you on a special diet?
- Yes  No Do you use Tobacco?
- Yes  No Do you use controlled substances?
- Yes  No Are you allergic to any of the following?  Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Local Anesthetics  Sulfa Drugs  Other \_\_\_\_\_
- Yes  No Are you taking any medications? If yes, please list below.

If yes to any of the above, please explain: \_\_\_\_\_

Women only:

- Yes  No Are you pregnant / trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?

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

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding         | <input type="checkbox"/> Cortisone Medicine          | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Recent Weight Loss         |
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Drug Addiction              | <input type="checkbox"/> Hepatitis A             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Easily Winded               | <input type="checkbox"/> Hepatitis B or C        | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Epilepsy or Seizures        | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Arthritis / Gout          | <input type="checkbox"/> Excessive Bleeding          | <input type="checkbox"/> Hives or Rash           | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Excessive Thirst            | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Fainting Spells / Dizziness | <input type="checkbox"/> Irregular Heartbeat     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Frequent Cough              | <input type="checkbox"/> Leukemia                | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Frequent Diarrhea           | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Breathing Problem         | <input type="checkbox"/> Frequent Headaches          | <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Bruise Easy               | <input type="checkbox"/> Genital Herpes              | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Hay Fever                   | <input type="checkbox"/> Neck Injuries           | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Pain in Jaw Joints      | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cold Sores / Fever        | <input type="checkbox"/> Heart Attack / Failure      | <input type="checkbox"/> Parathyroid Disease     | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Blisters                  | <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker            | <input type="checkbox"/> Psychiatric Care        |   |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Radiation Treatments    |   |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 (patient / guardian): \_\_\_\_\_ Date: \_\_\_\_\_