MEDICAL HISTORY FORM

PATIENT NAME ______________________________ BIRTH DATE ______________ DATE CREATED ______________

Although dental personnel primarily treat the area in 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.

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Condition	Yes / No
Aids / HIV Positive	❏ Yes ❏ No
Anemia	❏ Yes ❏ No
Anaphylaxis	❏ Yes ❏ No
Seasonal Allergies	❏ Yes ❏ No
High Blood Pressure	❏ Yes ❏ No
High Cholesterol	❏ Yes ❏ No
Hives or Rash	❏ Yes ❏ No
Sickle Cell Disease	❏ Yes ❏ No
Sinus Trouble	❏ Yes ❏ No
Blood Transfusion	❏ Yes ❏ No
Brith Defect(s)	❏ Yes ❏ No
Bruise Easily	❏ Yes ❏ No
Lung Disease	❏ Yes ❏ No
Chest Pains	❏ Yes ❏ No
Heart Murmur	❏ Yes ❏ No
Heart Pacemaker	❏ Yes ❏ No
Psychiatric Care	❏ Yes ❏ No
Cortisone Medicine	❏ Yes ❏ No
Diabetes	❏ Yes ❏ No
ADHD (Attention Deficit Hyperactivity Disorder)	❏ Yes ❏ No
Rheumatic Fever	❏ Yes ❏ No
Rheumatism	❏ Yes ❏ No
Scarlet Fever	❏ Yes ❏ No
Shingles	❏ Yes ❏ No
Asthma / Breathing Problems	❏ Yes ❏ No
Frequent Cough	❏ Yes ❏ No
Use of Diet Pills / Diet Aids (Including prescription)	❏ Yes ❏ No
Frequent Headaches	❏ Yes ❏ No
Low Blood Pressure	❏ Yes ❏ No
Thyrois Disease	❏ Yes ❏ No
Osteoporosis	❏ Yes ❏ No
Pain in Jaw Joints	❏ Yes ❏ No
Tobacco Use	❏ Yes ❏ No
Yellow Jaundice	❏ Yes ❏ No
Bleeding / Clotting Problems	❏ Yes ❏ No
Hepatitis	❏ Yes ❏ No
Disabilities / Special Needs	❏ Yes ❏ No
Angina	❏ Yes ❏ No
Arthritis / Gout	❏ Yes ❏ No
Artificial Heart Valve	❏ Yes ❏ No
Artificial Joints, Plates or Pins	❏ Yes ❏ No
Fainting Spells / Dizziness	❏ Yes ❏ No
Kidney Problems	❏ Yes ❏ No
Leukemia	❏ Yes ❏ No
Liver Disease	❏ Yes ❏ No
Cancer	❏ Yes ❏ No
Chemotherapy	❏ Yes ❏ No
Tuberculosis	❏ Yes ❏ No
Tumors or Growths	❏ Yes ❏ No
Ulcers	❏ Yes ❏ No
Pregnant	❏ Yes ❏ No
Radiations Treatments	❏ Yes ❏ No
Recent Weight Loss	❏ Yes ❏ No
Alcohol / Drug Abuse	❏ Yes ❏ No
Emphysema	❏ Yes ❏ No
Epilepsy or Seizures	❏ Yes ❏ No
Autism	❏ Yes ❏ No
Hypoglycemia	❏ Yes ❏ No
Speech / Hearing Problems	❏ Yes ❏ No
Spina Bifida	❏ Yes ❏ No
Stomach / Intestinal Disease	❏ Yes ❏ No
Stroke	❏ Yes ❏ No
Glaucoma	❏ Yes ❏ No
Tonsillitis	❏ Yes ❏ No
Cold Sores / Fever Blisters	❏ Yes ❏ No
Congenital Heart Disorder	❏ Yes ❏ No
Heart Trouble / Disease	❏ Yes ❏ No

COMMENTS ____

____

____

ARE YOU ALLERGIC TO ANY OF THIS FOLLOWING?

❏ Aspirin ❏ Metal ❏ Penicillin ❏ Latex ❏ Codeine ❏ Sulfa Drugs ❏ Acrylic ❏ Local Anesthetics

Are you being treated by a physician currently? If so, why ❏ Yes ❏ No If yes, ______________

Has the patient ever had surgery? If so what? ❏ Yes ❏ No If yes, ______________

Does the patient have any other health problems not addressed above? ❏ Yes ❏ No If yes, ______________

Is the patient taking any medications at this times (including over-the-counter medications such as) ❏ Yes ❏ No If yes, ______________

Does the patient have any dental problems / concerns at this time? If "Yes", please explain. ❏ Yes ❏ No If yes, ______________

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 (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** ______________