MEDICAL HISTORY PRINTED PATIENT NAME: _____

Although dental personnel primarily treat the area in and around the 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 for a condition? Yes ☐ No If yes, explain:_____
Have you ever been hospitalized or had major surgery? Yes No If yes, explain:_____
Have you ever had a serious head or neck injury? Yes No If yes, explain:_____
Are you taking any medications, pills or drugs? Yes No If yes, please list: _____
_____
_____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, explain:_____
Are you on a special diet? Yes No If yes, explain:_____
Do you use Tobacco? Yes No If yes, how much:_____
Do you use controlled substances? Yes No If yes, explain:_____

WOMEN: ARE YOU
(PLEASE CIRCLE ALL APPLICABLE) **NO** Pregnant/Planning pregnancy? Nursing? Use Oral Contraceptives?

Do you take Antibiotic premedication for your dental visits? If yes, explain:_____

Preferred Pharmacy Name and Number: _____

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
Other If yes, Please explain:_____

Do you have or have you had any of the following? Check mark all that apply below:

☐	Aids/HIV Positive	☐	Convulsions	☐	Heart Pace Maker	☐	Recent Weight Loss
☐	Alzheimer's/Dementia	☐	Cortisone Medicine	☐	Heart Disease	☐	Renal Dialysis
☐	Anaphylaxis	☐	Diabetes	☐	Hemophilia	☐	Rheumatic Fever
☐	Anemia	☐	Drug Addiction	☐	Hepatitis A B or C	☐	Rheumatism
☐	Angina	☐	Easily Winded	☐	Herpes	☐	Scarlet Fever
☐	Arthritis/Gout	☐	Emphysema	☐	High/Low Blood Pressure	☐	Shingles
☐	Artificial Heart Valve	☐	Epilepsy/Seizures	☐	Hives or Rash	☐	Sickle Cell
☐	Artificial Joint	☐	Excessive Bleeding	☐	Hypoglycemia	☐	Sinus Trouble
☐	Asthma	☐	Excessive Thirst	☐	Irregular Heartbeat	☐	Spina Bifida
☐	Blood Disease	☐	Fainting/Dizziness	☐	Jaudice	☐	Stomach/Intestinal Problems
☐	Blood Transfusion	☐	Frequent Cough	☐	Kidney Problems	☐	Stroke
☐	Breathing/Respiratory Problems	☐	Frequent Diarrhea	☐	Leukemia	☐	Swelling of Limbs
☐	Bruise Easily	☐	Frequent Headaches/Migraines	☐	Liver Disease	☐	Thyroid or Parathyroid Disease
☐	Cancer	☐	Glaucoma	☐	Lung Disease	☐	Tonsillitis
☐	Chemotherapy	☐	Hay Fever/Seasonal Allergies	☐	Mitral Valve Prolapse	☐	Tuberculosis
☐	Chest Pains	☐	Heart Attack/Failure	☐	Pain in Jaw Joints	☐	Tumor or Growths
☐	Cold Sores	☐	Low Blood Pressure	☐	Psychiatric Care	☐	Ulcers
☐	Congenital Heart Disorder	☐	Heart Murmur	☐	Radiation Treatments	☐	Other:

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

Have you been out of the country in past 6 months where you may have been exposed to a serious or life threatening sickness or disease?
Yes No If Yes, Where and Details?_____

If you are a NEW patient, how long has it been since you have seen a dentist? _____ Dental Concerns? Yes (list below) No

Additional 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_____