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 ha Have you ever had a serious Are you taking any medicat Do you take, or have you taken, F Are yo	nysician's care now? Yes No d a major operation? Yes No 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 ntrolled substances? Yes No	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:	
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No			
Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain:			
	Cortisone Medicine	Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No Hives or Rash Yes No Hypoglycemia Yes No Kidney Problems Yes No Leukemia Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Lung Disease Yes No Mitral Valve Prolapse Yes No Pain in Jaw Joints Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Radiation Treatments Yes No Recent Weight Loss Yes No	Renal Dialysis
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.			

_____ DATE _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____