



Medical History

Patient Name _____

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.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- 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 _____

Women: Are you
 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: _____

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

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

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

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 _____

UPDATES: For Office Use Only

1

PATIENT

Today's Date _____

Why have you come to the dentist today? _____

Any special concerns? _____

3

DENTAL INSURANCE

Insurance Co. Name _____

Policy/Group # _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Policyholder _____

Relationship _____

Insured's Birth Date ____ / ____ / ____

Insured's Member ID _____

Insured's Employer _____

Employer Tel. # _____

4

IN EVENT OF EMERGENCY

Is there someone who lives near you that we should contact?

Name _____

Relationship _____

Hm # _____

Cell # _____

Wk # _____

2

ABOUT YOU

Last Name _____

First Name _____

Middle _____

E-mail _____

SS # _____

DL # _____

Home Address _____
(no P. O. Box)

City _____ State _____ Zip _____

Hm # _____

Cell # _____

Wk # _____

Male Female Birth Date ____ / ____ / ____

Whom may we thank for referring you? _____

Previous Dentist _____

Employer _____

Address _____

City _____ State _____ Zip _____

Tel. # _____ Occupation _____

SPOUSE INFORMATION

Name _____

Employer _____

Birth Date ____ / ____ / ____

SS # _____

Hm # _____

Cell # _____

Wk # _____