Medical History

Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: ______________________________ Age: ________

Date: ____________________ Birth date: ________

If you are under a physician's care, please explain

____

Physician's Name & Telephone #

____

If you have been hospitalized, please explain

____

If you've had a head or neck injury, please explain

____

Personal Habits

We know these questions are an invasion of your privacy. We ask these questions to determine if our dental treatment or anesthesia needs to be modified to be effective. Your answers will remain confidential. We respect your privacy and right to choose your lifestyle and habits. Your honesty will help us better care for you.

Do you use tobacco products? ______________________________

Do you consume more than two alcoholic drinks a day? ______________________

Do you use controlled substances? ______________________________

Women, please check any of the following that apply to you:

__Pregnant (# of weeks ______) ___Nursing __Trying to get pregnant

__Taking oral contraceptives Last normal menstrual period? ________________

ALLERGIES Are you allergic to any of the following?

__Aspirin __Penicillin __Codeine __Latex __Acrylic __Metal __Epinephrine __Sulfa __ Benzocaine

__Other, please list______________________________

If you take prescribed medications, pill and drugs please complete this section.

Name of Drug	Reason for taking drug	How often do you take the drug

Please list supplements and/or herbal products you take

____

ILLNESS HISTORY Do you have or have you had any of the following?

	Yes	No		Yes	No
AIDS/HIV			Heart Pace Maker		
Alzheimer's Disease			Hepatitis A		
Angina			Hepatitis B or C		
Arthritis/Gout			Herpes		
Artificial Heart Valve			Hypoglycemia		
Asthma			High Blood Pressure		
Blood Disease			Irregular Heartbeat		
Bruise Easily			Kidney Problems		
Cold Sores/Fever Blisters			Liver Problems		
Congenital Heart Disorder			Low Blood Pressure		
Cortizone Medications			Pain in Jaw Joints		
Diabetes			Psychiatric Care		
Frequent Dry Mouth			Recent Weight Loss		
Emphysema			Renal Dialysis		
Epilepsy or Seizures			Stroke		
Excessive Bleeding			Swelling of Limbs		
Frequent Headaches			Thyroid Disease		
Glaucoma			Tuberculosis		
Heart Trouble/Disease			Ulcers		

If you have any serious illness not listed above, please explain

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If you take aspirin daily, what dose? ___ low dose (81mg) ___regular (325mg) Physician recommended?__________

If you have been treated for cancer, please explain:________________________ Year?______________

Chemotherapy?____________________ Radiation Treatments? ____________________

Have you been treated for osteoporosis or bone cancer? ____________________ Year? ______________

Medications taken ____

Do you have acid reflux? ______________ Is it controlled with medications? ____________________

Do you have high blood pressure? ______ How long? ________ Is it controlled with medications? ____________

Do you have an artificial joint? ______________When was it placed? ______________________

Did your physician and/or surgeon ask you to remain on antibiotics for dental treatments? ___________

Comments: ____

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I understand that providing inaccurate or incomplete medical information can be **dangerous to my health and compromise dental treatment** results. To the best of my knowledge, this medical history **form has been accurately answered. I also** understand that it is my responsibility to inform the dental **office of any changes** in **my medical status.**

Signature of patient or guardian ____ **Date** ____________

Dentist initials: ______