MEDICAL HISTORY

While we understand that we primarily treat the areas in and around your mouth, your mouth is an important part of your entire body. Any health issues you have or medications you are taking could be important to the type of dentistry you will receive. Therefore we thank you for answering the following questions accurately.

Primary Care Physician: _____

Have you ever been hospitalized or had a major operation? Yes:_____ No_____
If yes, please explain: _____

Have you had a serious neck or head injury? Yes:_____ No_____
If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes:_____ No_____
If yes, please explain: _____

Do you, or have you ever 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_____

Do you have an allergy to any of the following?

Aspirin _____	Local	Metal _____
Penicillin _____	Anesthetics_____	Latex _____
Codeine _____	Acrylic _____	Other _____

If other please explain: _____

Do you have or have you ever had:

__Aids/HIV Positive
__Alzheimer's
__Anaphylaxis
__Anemia
__Angina
__Arthritis/Gout
__Artificial Heart Valve
__Artificial Joint
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problem
__Bruise Easily
__Cancer
__Chemotherapy
__Chest Pains
__Cold Sores/Fever Blisters
__Congenital Heart Disorder
__Convulsions
__Cortisone Medicine
__Diabetes
__Drug Addiction
__Easily Winded
__Emphysema
__Epilepsy or Seizures
__Excessive Bleeding
__Excessive Thirst
__Fainting Spells/ Dizziness
__Frequent Cough
__Frequent Diarrhea
__Frequent Headaches
__Genital Herpes
__Glaucoma
__Hay Fever
__Heart Attack/Failure
__Heart Murmur
__Heart Pace Maker
__Heart Trouble/ Disease
__Hemophilia
__Hepatitis A
__Hepatitis B or C
__Herpes
__High Blood Pressure
__Hives or Rash
__Hypoglycemia
__Irregular Heartbeat
__Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Pain in jaw joints
__Parathyroid Disease
__Psychiatric Care
__Radiation Treatments
__Recent Weight Loss
__Renal Dialysis
__Rheumatic Fever
__Rheumatism
__Scarlet Fever
__Shingles
__ Sickle Cell Disease
__Sinus Trouble
__Spina Bifida
__Stomach/Intestinal Disease
__Stroke
__Swelling of Limbs
__Thyroid Disease
__Tonsillitis
__Tuberculosis
__Tumors or Growths
__Ulcers
__Venereal Disease
__Yellow Jaundice

Have you ever had any illness not listed above? _____

Comments:

Signature_____Date_____

Dr./Hygeinist_____Date_____