MEDICAL HISTORY

Are you currently under the care of a physician? ❑ Yes ❑ No If yes, for what condition?_____
Have you ever been hospitalized or had major surgery? ❑ Yes ❑ No If yes, for what condition?_____
Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, for what condition?_____
Please list all the medications you are taking:_____
Do you use tobacco? If yes, how much?_____
Are you on a special diet? If yes, what kind?_____
WOMEN: Are you pregnant? ❑ Yes ❑ No Trying to get pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No
Are you taking contraceptives? ❑ Yes ❑ No
Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Latex ❑ Metal ❑ Local Anesthetics ❑ Other:_____
Pharmacy:_____ Phone No:_____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ 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
- ❑ Diabetes
- ❑ Dialysis
- ❑ Drug Addiction
- ❑ Eating Disorder
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Diarrhea
- ❑ Frequent Cough
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Gout
- ❑ 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
- ❑ Hormone Treatment
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Migraines
- ❑ Mitral Valve Prolapse
- ❑ Parathyroid Disease
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Radiation Therapy
- ❑ Recent Weight Loss
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ TMJ/Pain in Jaw
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers

Have you had any of the following surgically placed? ❑ Pins ❑ Screws ❑ Rods ❑ Plates ❑ Implants ❑ Other
If you answered yes to any of the above, when were they placed?_____
Please list any condition not mentioned above:_____
Primary Medical Doctor: Name:_____ Phone No:_____
Cardiologist: Name:_____ Phone No:_____
Orthopedic Surgeon: Name:_____ Phone No:_____
Oncologist: Name:_____ Phone No:_____
Other:_____

IF YOU MUST CANCEL YOUR APPOINTMENT WE URGE YOU TO GIVE US AT LEAST 48 HOURS NOTICE SO THAT PATIENTS ON OUR WAITING LIST CAN BE SCHEDULED IN YOUR PLACE. FAILURE TO GIVE US 48 HOURS NOTICE COULD RESULT IN A BROKEN APPOINTMENT CHARGE. PLEASE INITIAL_____

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 patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE