Dental Medical History Form (Version 8/2015)

Patient Name: _____ Birth Date: _____

Although we primarily treat the area in and around the mouth, one's mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions as completely as possible. Thank you!

Is the patient under a physician's care now?	O Yes O No	If yes _____
Has the patient ever been hospitalized or had a major operation?	O Yes O No	If yes _____
Has the patient had a serious head or neck injury?	O Yes O No	If yes _____
Is the patient taking medications, pills, or drugs?	O Yes O No	If yes _____
Does the patient take, or have taken, Phen-Fen or Redux?	O Yes O No	If yes _____
Is the patient on a special diet?	O Yes O No	If yes _____
Does the patient use tobacco?	O Yes O No	If yes _____
Please list previous hospitalizations/Surgeries/Serious Illnesses?	O Yes O No	If yes _____

Women: Are You...? O Pregnant/Trying to get pregnant O Nursing O Taking Oral Contraceptives

Is the patient allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic
O Metal O Latex O Local Anesthetics

Other Allergy? O Yes O No If yes _____

Does the patient have or had, any of the following?

ADD/ADHD O Yes O No	Convulsions O Yes O No	Heart Pacemaker O Yes O No	Recent Weight Loss O Yes O No
AIDS/HIV Positive O Yes O No	Cortisone Medicine O Yes O No	Heart Trouble/Disease O Yes O No	Renal Dialysis O Yes O No
Anaphylaxis O Yes O No	Diabetes I O Yes O No	Hemophilia O Yes O No	Rheumatic Fever O Yes O No
Anemia O Yes O No	Diabetes II O Yes O No	Hepatitis A O Yes O No	Rheumatism O Yes O No
Angina O Yes O No	Down Syndrome O Yes O No	Hepatitis B or C O Yes O No	Scarlet Fever O Yes O No
Anxiety' Disorder O Yes O No	Drug Addiction O Yes O No	Herpes O Yes O No	Shingles O Yes O No
Arthritis/Gout O Yes O No	Easily Winded O Yes O No	High Blood Pressure O Yes O No	Sickle Cell Disease O Yes O No
Artificial Heart Valve O Yes O No	Emphysema O Yes O No	High Cholesterol O Yes O No	Sinus Trouble O Yes O No
Artificial Joint O Yes O No	*Epilepsy or Seizures O Yes O No	Hives or Rash O Yes O No	Special Needs/
Asperger's O Yes O No	Excessive Bleeding O Yes O No	Hypoglycemia O Yes O No	Developmental Delay O Yes O No
Asthma O Yes O No	Excessive Thirst O Yes O No	Irregular Heartbeat O Yes O No	Spina Bifida O Yes O No
Autism O Yes O No	Fainting Spells/Dizziness O Yes O No	Kidney Problems O Yes O No	Stomach/Intestinal Disease O Yes O No
Blood Disease O Yes O No	Fetal Alcohol Syndrome O Yes O No	Leukemia O Yes O No	Stroke O Yes O No
Blood Transfusion O Yes O No	Frequent Cough O Yes O No	Liver Disease O Yes O No	Swelling of Limbs O Yes O No
Breathing Problems O Yes O No	Frequent Diarrhea O Yes O No	Low Blood Pressure O Yes O No	Thyroid Disease O Yes O No
Bruise Easily O Yes O No	Frequent Headaches O Yes O No	Lung Disease O Yes O No	Tonsillitis O Yes O No
Cancer O Yes O No	Genital Herpes O Yes O No	Mitral Valve Prolapse O Yes O No	Tuberculosis O Yes O No
Chemotherapy O Yes O No	Glaucoma O Yes O No	Pain in Jaw Joints O Yes O No	Tumors or Growths O Yes O No
Chest Pains O Yes O No	Hay Fever O Yes O No	Parathyroid Disease O Yes O No	Ulcers O Yes O No
Cold Sores/Fever Blisters O Yes O No	Heart Attack/Failure O Yes O No	Psychiatric Care O Yes O No	Venereal Disease O Yes O No
Congenital Heart Disorder O Yes O No	*Heart Murmur O Yes O No	Radiation Treatments O Yes O No	Yellow Jaundice O Yes O No

*If Heart Murmur, does the patient require antibiotics prior to dental treatment? O Yes O No If yes _____

*If Epilepsy or Seizures, date of last seizure? O Yes O No If yes _____

Has the patient ever had any serious illness or condition not listed above? O Yes O No If yes _____

Does the patient have any of the following habits?

O Sucking thumb/finger O Suck/Bite Lip O Chew/Bite nails
O Chew hard objects O Grind Teeth O Clench Jaw

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 the patients' health. It is my responsibility to inform the dental office of any changes in the patients' medical status. I also authorize the dental staff to perform the necessary dental services the patient may need.

X_____ _____
Signature of Patient, Parent or Guardian Date

This form has been reviewed with Patient, Parent or Guardian and conditions accurately notated.

X_____ _____
Signature of Providing Dentist Date