



### MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 that you will be receiving. Thank you for answering the following questions:

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Your Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

A. Do you have or have you had any of the following conditions? (If yes, please explain)

- Hospitalization for illness, injury or surgery \_\_\_\_\_
- Allergic Reaction to:
  - Aspirin, ibuprofen, acetaminophen
  - Penicillin, erythromycin, tetracycline
  - Codeine
  - Local anesthetic
  - Hives, skin rash, hayfever
  - Fluoride
  - Metals
  - Latex
  - Any other medications: \_\_\_\_\_

<input type="checkbox"/> Rheumatic Fever/Scarlet Fever <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Prosthetic Heart Valve <input type="checkbox"/> Joint Replacement or Implants <input type="checkbox"/> Have taken Phen/fen (Redux or Pondamin)	<input type="checkbox"/> Compromised Immune System <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Viral Infection and Cold Sores
<input type="checkbox"/> Heart Problems <input type="checkbox"/> Angina (chest pain) <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sinus Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Anemia <input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney, Stomach, Thyroid or Liver Problems <input type="checkbox"/> Hepatitis (Type ____) <input type="checkbox"/> Jaundice <input type="checkbox"/> Digestive / Eating Disorders <input type="checkbox"/> Stomach or Duodenal Ulcer <input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Have taken medicines for osteoporosis or breast cancer	<input type="checkbox"/> Mental Health Care <input type="checkbox"/> Alcohol / Drug Dependency
<input type="checkbox"/> Glaucoma <input type="checkbox"/> Epilepsy / Seizures / Fainting	<input type="checkbox"/> Head or Neck Injuries <input type="checkbox"/> Lumps or Swelling in the Mouth

B. Circle any of the following you may use: Cigarettes, Cigars, Pipe, Chewing Tobacco, Cocaine or Amphetamines

C. **Women Only:** Pregnant, Nursing, Taking Birth Control Pills

D. Please list any prescription, over the counter medications or herbal supplements you are taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your Physician's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_