Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of you entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you receive. Thank you for answering the following questions.

Yes No 1. Have you been under the care of a physician during the past two years?
If yes,
For____
Date of last physical exam____________________
Hospital or Clinic Name______________________
Physician's Name___________________________
Physician's Phone___________________________
Pharmacy Name_____________________________
Pharmacy Phone_____________________________

Yes No 2. Have you ever been hospitalized or had a major operation?
If yes, please explain______________________________________

Yes No 3. Have you ever been told to take a premedication before dental appointments?

Yes No 4. Have you ever had an allergic (or adverse) reaction to any of the following? Please check the appropriate box(es).

☐Aspirin	☐Penicillin	☐Codeine
☐Acrylic	☐Metals	☐Latex
☐Sulfa drugs	☐Hay fever	☐Seasonal
☐Local anesthetics	☐Other_______________	

5. For women,
Yes No are you taking birth control pills?
Yes No are you nursing?
Yes No are you pregnant? _____________months

6. Do you have, or have you had, any of the following? Please check the appropriate box(es)

Cardiovascular

☐Aneurysm	☐Congenital Heart Defect	☐Congestive Heart Failure	☐High Cholesterol
☐Heart Attack	☐Irregular Heart Beat	☐Pacemaker/Defibrillator	☐Rheumatic Fever
☐Chest Pain	☐Low Blood Pressure	☐Heart Transplant	☐Heart Surgery
☐Stroke	☐High Blood Pressure	☐Mitral Valve Prolapse	☐Other____________
☐Heart Murmur	☐Artificial/Prosthetic Heart Valve		

Dermatologic

☐Eczema	☐Psoriasis	☐Chicken Pox	☐Night Sweats
☐Rosacea	☐Changes in appearance of Moles	☐Shingles	☐Other_____________

Endocrine

☐Diabetes	☐Parathyroid Disease	☐Hormonal Dysfunction	☐Other_____________
☐ Gout	☐Hypoglycemia	☐Thyroid Disease	

Gastrointestinal

☐Colitis	☐Special or Restricted Diet	☐ Tonsils Removed	☐Chron's Disease
☐Hepatitis	☐Stomach or Intestinal Ulcers	☐Yellow Jaundice	☐Eating Disorder
☐Cirrhosis	☐Recent Weight Loss or Gain	☐Persistent Diarrhea	☐Other_____________

Genitourinary

☐Dialysis	☐Kidney or Bladder Problem	☐Urinate Frequently	☐Gonorrhea
☐Syphilis	☐Multiple Sexual Partners	☐Kidney Transplant	☐Genital Herpes
☐Chlamydia	☐Human Papilloma Virus	☐AIDS or HIV positive	☐Other______________

6. Do you have, or have you had, any of the following? Please check the appropriate box(es).

Hematologic			
☐Anemia	☐Blood Transfusion	☐Excessive Bleeding	☐Other______________
☐Leukemia	☐Sickle Cell Anemia	☐Hemophilia	
Musculoskeletal			
☐Osteoarthritis	☐Muscular Dystrophy	☐Spina bifida	☐Neurofibromatosis
☐Osteoporosis	☐Ankylosing Spondylitis	☐Fibromyalgia	☐Other_____________
☐Systemic Lupus	☐Artificial/Prosthetic Joint Replacement	☐Rheumatoid Arthritis	
Neurologic			
☐Vision Problems	☐Developmental Disability	☐Nervousness or Anxiety	☐ Cerebral Palsy
☐Hearing Loss	☐Earaches, Ringing in Ears	☐Severe Headaches	☐Glaucoma
☐Phobias	☐ Fainting or Dizzy Spells	☐Multiple Sclerosis	☐Schizophrenia
☐ADHD	☐Epilepsy, Seizures or Convulsions	☐Panic Attacks	☐Other_____________
☐Alzheimer's	☐Alcohol or Drug Abuse	☐Depression	
Respiratory			
☐Asthma	☐Bronchitis	☐Emphysema	☐Pneumonia
☐COPD	☐Tuberculosis	☐Sinus Trouble	☐Breathing Problems
☐Sinus Trouble	☐Allergies or Hives	☐Chronic Cough	☐Other_____________
Other Conditions			
☐Cancer or Tumor	☐Trauma/Injury to the head or neck	☐Recurring Infection of any kind	
☐Chemotherapy	☐Radiation Therapy	☐A High Fever before age two	

Yes No 7. Do you have or have you had a disease, condition, or problem not listed above?
If yes, please explain____

Yes No 8. Do you use tobacco (smoke/smokeless)?
If yes,
How many packs or cans per day? _________
For how many years? ___________________________

9. Are you taking or have you taken any of the following medications? Please check the appropriate box(es).

☐High blood pressure meds ☐Blood thinners ☐Aspirin
☐Drugs for bone health ☐Steroids/cortisone ☐Ibuprofen
☐ Insulin ☐Drugs to assist in weight loss/gain

10. Are you taking any pills or drugs, including over-the-counter medications, herbal or nutritional supplements? Please provide a copy of your list or list them here:

____ reason ____
____ reason ____
____ reason ____
____ reason ____
____ reason ____
____ reason ____
____ reason ____
____ reason ____
____ reason ____
____ reason ____