

MEDICAL HISTORY

Patient Name _____

Date: _____

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

Are you under a physician's care now? Yes No

If yes, name of doctor & phone # _____

Have you ever had a serious head or neck injury? Yes No

If yes, what and date _____

Do you take or have you taken Phen-Fen or Redux? Yes No

If yes, for how long? _____ As a result, did you see a cardiologist? _____

Do you smoke or chew tobacco? Yes No

***For Women Only:** Pregnant/ Might be pregnant? Nursing Taking oral contraceptives

Are you allergic to any of the following:

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthesia Sulfa Drugs
- Barbituates, Sedatives, etc. Food Allergies -- Explain: _____
- Other _____

Do you have, or have you had, any of the following:

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Bones | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer- Chemotherapy | <input type="checkbox"/> Colitis | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV+, AIDS | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Radiation Tx |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Shingles | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No

If yes, explain: _____

I am interested in invisible braces Yes No

I am interested in cosmetic dentistry Yes No

I am interested in bleaching (whitening my teeth) Yes No

Please list any medications or supplements you are taking on the back of this form. Thank you.

Signature of patient _____

Date _____