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:

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

Signature of patient_____ **Date**_____