MEDICAL HISTORY

PATIENT NAME		Birth Date	
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may			
have, or medication that you may be ta following questions.	king, could have an important interrelat	ionship with the dentistry you will receive	e. Thank you for answering the
Have you ever been hospitalized or ha Have you ever had a serious	nysician's care now? Yes No d a major operation? Yes No head or neck injury? Yes No ions, pills, or drugs? Yes No	If yes, please explain: If yes, please explain: If yes, please explain: If yes, please explain:	
Do you take, or have you taken, F Are yo D	Phen-Fen or Redux? Yes No but on a special diet? Yes No No you use tobacco? Yes No		
Do you use controlled substances?			
Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain:			
	Cortisone Medicine Yes No Diabetes Yes No Drug Addiction Yes No Easily Winded Yes No Emphysema Yes No Excessive Bleeding Yes No Fainting Spells/Dizziness Yes No Frequent Cough Yes No Frequent Headaches Yes No Genital Herpes Yes No Glaucoma Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Pace Maker	Hepatitis A	Renal Dialysis
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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.			

_____ DATE _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____