MEDICAL HISTORY

PATIENT NAME _____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 taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical Doctor: _____ MD's Town _____Date of Last Visit: _____ Don't Have Medical Dr._____

	YES	NO
Are you in good health at this time	❑	❑
Ever taken osteoporosis drugs	❑	❑
Take blood thinners (not aspirin)	❑	❑
Take any prescription/OTC drugs	❑	❑
Have you had major surgery	❑	❑
Ever had Chemo/Radiation	❑	❑
Ever had alcohol abuse treatment	❑	❑
Ever had drug abuse treatment	❑	❑
Are you under medical treatment	❑	❑
Have you had a head injury	❑	❑
Any joint replacements	❑	❑
Have you ever used Meth	❑	❑
Do you smoke	❑	❑
Do you use smokeless tobacco	❑	❑
Have you had psychological counseling?	❑	❑
Are you in a pain management program?	❑	❑

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

Mental/learning disability ❑ ❑	Cancer ❑ ❑	Hypoglycemia ❑ ❑
If yes, explain _____	If yes, explain _____	Heart Condition or Surgery ❑ ❑
_____	_____	If yes, explain _____
Depression ❑ ❑	Tuberculosis ❑ ❑	Cardiologist's Name _____
Anxiety Disorder ❑ ❑	High Blood Pressure ❑ ❑	_____
Hepatitis ❑ ❑	Low Blood Pressure ❑ ❑	*Diabetes ❑ ❑
If yes, note Hepatitis A, B, C, etc. _____	Sexually Transmitted Disease (STD) ❑ ❑	*Type I ❑ or Type II ❑
Liver Disease ❑ ❑	MRSA Infection ❑ ❑	*Do you take insulin? ❑ ❑
Kidney Disease ❑ ❑	Decreased Immunity ❑ ❑	Any medical condition not listed? ❑ ❑
Epilepsy or Seizures/Convulsions ❑ ❑	Sinus Trouble ❑ ❑	If yes, please explain:
Glaucoma ❑ ❑	Bell's Palsy ❑ ❑	_____
Bulimia or Anorexia ❑ ❑	Osteoarthritis ❑ ❑	Women are you:
Stroke ❑ ❑	Rheumatoid Arthritis ❑ ❑	Pregnant ❑ ❑
Respiratory Disorder ❑ ❑	Colitis or any intestinal disorder ❑ ❑	Trying to get pregnant ❑ ❑
Asthma ❑ ❑	Stomach Ulcers or Disease ❑ ❑	Nursing ❑ ❑
Frequent Headaches ❑ ❑	Persistent Cough ❑ ❑	Taking oral contraceptives ❑ ❑
Wound or Healing Problems ❑ ❑	Alzheimer's Disease ❑ ❑	
Blood Disease/ Bleeding Disorder ❑ ❑	Autoimmune Disease ❑ ❑	

Are you allergic to any of the following?

	YES	NO		YES	NO
Latex Gloves	❑	❑	Penicillin	❑	❑
Aspirin	❑	❑	Codeine	❑	❑
Acrylic	❑	❑	Local Anesthetic	❑	❑
Metal of any kind	❑	❑	Pine nuts	❑	❑
Ibuprofen	❑	❑	Other allergy please list _____	❑	❑

Patient/Guardian Signature _____ Date _____

For Office Use Only

Reviewed by _____ Date_____ Reviewed by _____ Date_____ Reviewed by _____ Date_____