PATIENT MEDICAL HISTORY

First Name:_____ **Last Name:**_____ **Today's 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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Physician's Name: _____
Address: _____
City: _____ **State:** _____ **Zip:**_____
E-mail Address: _____
Phone: _____ **Fax:**_____

Have you ever been hospitalized or had a major operation? □ **Yes** □ **No**
Please list:_____
Have you ever had a serious head or neck injury? □ **Yes** □ **No**
Please list:_____
Are you taking any Rx or OTC medications, pills, or drugs? □ **Yes** □ **No**
Please list:_____

Do you take, or have you taken, Phen-Fen or Redux? □ **Yes** □ **No**
Have you taken Fosomax, Boniva, Actonel or any bisphosphonates? □ **Yes** □ **No**
Are you on a special diet? □ **Yes** □ **No**
Do you use tobacco? □ **Yes** □ **No**
Do you use controlled substances? □ **Yes** □ **No**

The next three questions are specifically for FEMALE PATIENTS:
Are you trying to get pregnant? □ **Yes** □ **No**
Are you taking oral contraceptives? □ **Yes** □ **No**
Are you nursing? □ **Yes** □ **No**

Are you allergic to any of the following?
□ **Aspirin** □ **Penicillin** □ **Codeine** □ **Acrylic** □ **Metal** □ **Latex** □ **Local Anesthetics** □ **Sulfa**
□ **Other: (explain)**_____

www.DentalWellnessCenterGA.com

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

AIDS/HIV Positive	□ Yes	□ No	**Hemophilia**	□ Yes	□ No
Alzheimer's Disease	□ Yes	□ No	**Hepatitis A**	□ Yes	□ No
Anaphylaxis	□ Yes	□ No	**Hepatitis B or C**	□ Yes	□ No
Anemia	□ Yes	□ No	**Herpes**	□ Yes	□ No
Angina	□ Yes	□ No	**High Blood Pressure**	□ Yes	□ No
Arthritis/Gout	□ Yes	□ No	**Hives or Rash**	□ Yes	□ No
Artificial Heart Valve	□ Yes	□ No	**Hypoglycemia**	□ Yes	□ No
Artificial Joint	□ Yes	□ No	**Irregular Heartbeat**	□ Yes	□ No
Asthma	□ Yes	□ No	**Kidney Problems**	□ Yes	□ No
Blood Disease	□ Yes	□ No	**Leukemia**	□ Yes	□ No
Blood Transfusion	□ Yes	□ No	**Liver Disease**	□ Yes	□ No
Breathing Problems	□ Yes	□ No	**Low Blood Pressure**	□ Yes	□ No
Bruise Easily	□ Yes	□ No	**Lung Disease**	□ Yes	□ No
Cancer	□ Yes	□ No	**Mitral Valve Prolapse**	□ Yes	□ No
Chemotherapy	□ Yes	□ No	**Pain In Jaw Joints**	□ Yes	□ No
Chest Pains	□ Yes	□ No	**Parathyroid Disease**	□ Yes	□ No
Cold Sores/Fever Blisters	□ Yes	□ No	**Psychiatric Care**	□ Yes	□ No
Congenital Heart Disorder	□ Yes	□ No	**Radiation Treatments**	□ Yes	□ No
Convulsions	□ Yes	□ No	**Recent Weight Loss**	□ Yes	□ No
Cortisone Medicine	□ Yes	□ No	**Renal Dialysis**	□ Yes	□ No
Diabetes	□ Yes	□ No	**Rheumatic Fever**	□ Yes	□ No
Drug Addiction	□ Yes	□ No	**Rheumatism**	□ Yes	□ No
Easily Winded	□ Yes	□ No	**Scarlet Fever**	□ Yes	□ No
Emphysema	□ Yes	□ No	**Shingles**	□ Yes	□ No
Epilepsy or Seizures	□ Yes	□ No	**Sickle Cell Disease**	□ Yes	□ No
Excessive Bleeding	□ Yes	□ No	**Sinus Trouble**	□ Yes	□ No
Excessive Thirst	□ Yes	□ No	**Spina Bifida**	□ Yes	□ No
Fainting Spells/Dizziness	□ Yes	□ No	**Stomach Disease**	□ Yes	□ No
Frequent Cough	□ Yes	□ No	**Intestinal Disease**	□ Yes	□ No
Frequent Diarrhea	□ Yes	□ No	**Stroke**	□ Yes	□ No
Frequent Headaches	□ Yes	□ No	**Swelling of Limbs**	□ Yes	□ No
Genital Herpes	□ Yes	□ No	**Thyroid Disease**	□ Yes	□ No
Glaucoma	□ Yes	□ No	**Tonsillitis**	□ Yes	□ No
Hay Fever	□ Yes	□ No	**Tuberculosis**	□ Yes	□ No
Heart Attack/Failure	□ Yes	□ No	**Tumors or Growths**	□ Yes	□ No
Heart Murmur	□ Yes	□ No	**Ulcers**	□ Yes	□ No
Heart Pace Maker	□ Yes	□ No	**Venereal Disease**	□ Yes	□ No
Heart Trouble/Disease	□ Yes	□ No	**Yellow Jaundice**	□ Yes	□ No

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

Please explain:_____

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.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:_____ **Date:**_____

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