MEDICAL HISTORY

Are you under a physician's care now? _____Have you ever been hospitalized?_____

If so, why? _____

Are you taking any medications, pills or drugs?(please list) _____

Do you take, or have you ever taken, Phen-Fen or Redux? (when)_____

Are you on a special diet? _____

Do you use tobacco products? _____How often?_____

Do you use controlled substances? _____

Are you pregnant/trying to get pregnant?_____ Nursing_____ Taking oral contraceptives_____

Are you allergic to any of the following? (Please circle)

Aspirin Penicillin Codeine Metal Local Anesthetics Sulfa Latex Other_____

If other, please explain _____

Do you have, or have you ever had, any of the following? (Please circle)

AIDS/HIV Positive	Cold Sores	Genital Herpes	Liver Disease	Spina Bifida
Alzheimer's Disease	Congenital Heart Disorder	Glaucoma	Low Blood Pressure	Stomach/Intestinal Disease
Anaphylaxis	Convulsions	Hay Fever	Mitral Valve Prolapse	Stroke
Anemia	Cortisone Medication	Heart Attack/Failure	Pain in Jaw Joint	Swelling of Limbs
Angina	Diabetes	Heart Disease	Parathyroid Disease	Thyroid Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Psychiatric Care	Tonsillitis
Artificial Joint	Easily Winded	Hemophilia	Radiation Treatment	Tuberculosis
Asthma	Emphysema	Hepatitis A	Recent weight loss	Tumors or Growths
Blood Disease	Epilepsy or Seizures	Hepatitis B or C	Renal Dialysis	Ulcers
Blood Transfusion	Excessive Bleeding	High Blood Pressure	Rheumatic Fever	Yellow Jaundice
Breathing Problem	Excessive Thirst	Hives or Rash	Rheumatism	
Bruise Easily	Fainting Spells/Dizziness	Hypoglycemia	Scarlet Fever	
Cancer	Frequent Cough	Irregular Heartbeat	Shingles	
Chemotherapy	Frequent Diarrhea	Kidney Problems	Sickle cell	
Chest pains	Frequent Headaches	Leukemia	Sinus Trouble	

NOTES:_____

_____

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: _____

Print Name: _____Doctor's Signature: _____