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 taking, could have an important interrelationship 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, please explain: Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Have you ever had a serious head or neck injury? Yes No If yes, please explain: Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, or have you taken, Phen-Fen or Redux? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Women: Are you Yes No Nursing? Yes No Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No	
Are you allergic to any of the following?	
Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Angina Yes No Angina Yes No Antrificial Heart Valve Yes No Artificial Joint Yes No Excessive Bleeding Yes No Asthma Yes No Elood Disease Yes No Frequent Dearthea Yes No Broad Transfusion Yes No Frequent Headaches Yes No Bruise Easily Yes No Frequent Headaches Yes No Cancer Yes No Galaucoma Yes No Cherry Yes No Heart Murmur Yes No Stroke Yes No Broad Transfusion Yes No Frequent Caugh Yes No Stroke Stroke Yes No	
Comments:	
	tions on this form have been accurately answered. I understand that providing incorrect information can be It is my responsibility to inform the dental office of any changes in medical status.