New Patient

MEDICAL HISTORY

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?	Y N	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Y N	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Y N	If yes, please explain: _____
Are you taking medications, pills or drugs?	Y N	If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux?	Y N	If yes, please explain: _____
Are you on a special diet?	Y N	If yes, please explain: _____
Do you use tobacco?	Y N	If yes, please explain: _____
Do you use controlled substances?	Y N	If yes, please explain: _____

Women: Are you

Pregnant/Trying to get pregnant	Y N
Taking oral contraceptives	Y N
Nursing	Y N

Are you allergic to any of the following? If so, please circle.

Aspirin Penicillin Codeine Metal Latex Sulfa Local Anesthetics

Other:_____

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

Y N AIDS/HIV Positive	Y N Excessive Thirst	Y N Lung Disease
Y N Alzheimer's Disease	Y N Fainting Spells/Dizziness	Y N Mitral Valve Prolapse
Y N Anaphylaxis	Y N Frequent Cough	Y N Pain in Jaw Joints
Y N Anemia	Y N Frequent Diarrhea	Y N Parathyroid Disease
Y N Angina	Y N Frequent Headaches	Y N Psychiatric/Depression
Y N Arthritis/Gout	Y N Genital Herpes	Y N Radiation Therapy
Y N Artificial Joint	Y N Glaucoma	Y N Recent Weight Loss
Y N Asthma	Y N Hay Fever	Y N Renal Dialysis
Y N Blood Disease	Y N Heart Attack/Failure	Y N Rheumatic Fever
Y N Blood Transfusion	Y N Heart Murmur	Y N Rheumatism
Y N Breathing Problem	Y N Heart Pacemaker	Y N Scarlet Fever
Y N Bruise Easily	Y N Heart Trouble/Disease	Y N Shingles
Y N Cancer	Y N Hemophilia	Y N Sickle Cell Disease
Y N Chemotherapy	Y N Hepatitis A	Y N Sinus Trouble
Y N Chest Pains	Y N Hepatitis B or C	Y N Spina Bifida
Y N Cold Sores/Fever Blisters	Y N Herpes	Y N Stomach/Intestinal
Y N Congenital Heart Disorder	Y N High Blood Pressure	Y N Stroke
Y N Convulsions	Y N High Cholesterol	Y N Swelling of Limbs
Y N Cortisone Medicine	Y N Hives or Rash	Y N Thyroid Disease
Y N Diabetes	Y N Hypoglycemia	Y N Tonsillitis
Y N Drug Addition/Alcoholism	Y N Irregular Heartbeat	Y N Tuberculosis
Y N Easily Winded	Y N Kidney Problems	Y N Tumors/Growths
Y N Emphysema	Y N Leukemia	Y N Ulcers
Y N Epilepsy or Seizures	Y N Liver Disease	Y N Venereal Disease
Y N Excessive Bleeding	Y N Low Blood Pressure	Y N Yellow Jaundice

Have you ever had a serious illness not listed above? If so, please explain:_____

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.

SIGNATURE OF PATIENT, PARENT or GUARDIAN:_____ DATE:_____