Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 that you will be receiving. Thank you for answering the questions below.

	Yes	No
1. Have you ever been hospitalized, or have you had any major operations or serious illness? If so, what?__________		
2. Are you under any medical treatment now? If so, please give the reason.__________		
3. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin?		
4. Has there been a change in your health in the past year?		
5. Have you ever had a blood transfusion?		
6. Have you ever had kidney dialysis treatment?		
7. Have you ever had abnormal bleeding problems after a cut or a tooth extraction?		
8. Are you now taking drugs or medications? If so, what?__________		

9. Has a physician ever informed you that you had:

	Yes	No		Yes	No
Heart Ailment……………………………………			Anemia……………………………………		
High Blood Pressure………………………..			Hepatitis or Yellow Jaundice………….		
Rheumatic Fever……………………………			Liver Disease…………………………….		
Heart Murmur………………………………..			Venereal Disease……………………….		
Mitral Valve Prolapse………………………			AIDS, ARC or HIV Positive……………		
Angina………………………………………..			Stomach or Intestinal Disease………..		
Stroke…………………………………………			Kidney Disease………………………….		
Blood Disease..………………………………			Tumors or Growths……………………..		
Hemophilia or other Bleeding Disorders….			Diabetes………………………………….		
Asthma………………………………………			Tuberculosis……………………………..		
Thyroid Problem……………………………..			Respiratory Disease…………………….		
			Epilepsy or Seizures……………………		

	Yes	No
10. Women: A. Are you pregnant?.............		
B. Estimated date of delivery__________		
11. Have you ever had heart surgery or a heart attack?		
12. Do you have an artificial joint, prosthetic heart valve or pacemaker?		
13. Is there any other information that should be known about your health history?		

MEDICAL ALERTS (office use only)

BLOOD PRESSURE: PULSE:

If so, please explain ____________________

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14. When was your last physical examination?__________

Physician's Name__________ Phone __________

X__________ Date__________

Patient signature (parent or guardian)

Reviewed by Doctor__________

(PLEASE COMPLETE THE OTHER SIDE)