Patient Information

Date _____

Full Name _____ _____ Birth Date

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 that you will be receiving. Thank you for answering the following questions.

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

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

	Yes	No		Yes	No
Heart Ailment	☐	☐	Hepatitis or Yellow Jaundice	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Venereal Disease	☐	☐
Heart Murmur	☐	☐	AIDS	☐	☐
Mitral Valve Prolapse	☐	☐	Stomach or Intestinal Disease	☐	☐
Angina	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Tumors or Growths	☐	☐
Blood Disease	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Respiratory Disease	☐	☐
			Epilepsy	☐	☐

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women: A. Are you pregnant?	☐	☐
B. Estimated Date of Delivery _____		

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST)		

Signature _____ Date _____

Updating _____

_____

_____

_____

_____

Medical History Summary

Blood Pressure: _____