MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

3Dental DeWispelare Family Dentistry

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: _____
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

Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics
❑ Other If yes, please explain: _____

AIDS/HIV Positive	❑ Yes ❑ No	Excessive Bleeding	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No
Alzheimer's Disease	❑ Yes ❑ No	Excessive Thirst	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Fainting Spells/Dizziness	❑ Yes ❑ No	Pain in Jaw Joints	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Frequent Cough	❑ Yes ❑ No	Parathyroid Disease	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No	Radiation Treatments	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No	Rheumatism	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Breathing Problem	❑ Yes ❑ No	Heart Pace Maker	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Heart Trouble/Disease	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No	Spina Bifida	❑ Yes ❑ No
Chest Pains	❑ Yes ❑ No	Hepatitis B or C	❑ Yes ❑ No	Stomach/Intestinal Disease	❑ Yes ❑ No
Cold Sores/Fever Blisters	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Congenital Heart Disorder	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Convulsions	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Cortisone Medicine	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Drug Addiction	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Easily Winded	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Epilepsy or Seizures	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No

Have you ever had any serious illness not listed above ❑ Yes ❑ No If yes, 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 _____