MEDICAL INFORMATION

NAME:_____ DATE:_____

PERSONAL PHYSICIAN:_____ OFFICE PH #:_____

(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 inter-relationship with the dentistry you will receive.)

(if YES, please explain)

- Are you currently under the care of a physician for a specific issue? YES / NO _____
- Have you ever been hospitalized or had a major operation? YES / NO _____
- Have you ever had a serious head or neck injury? YES / NO _____
- **Do you have an allergy to LATEX? YES / NO**
- **Do you have any allergies to MEDICATIONS? YES / NO** _____
- Are you taking any **MEDICATIONS,** including non-prescription? *(use back of form if needed)* **YES / NO** _____
- Do you use controlled substances? YES / NO _____
- Do you use tobacco? YES / NO _____
- Have you ever experienced any problems in your jaw? *(clicking jaw/pain near side of face)* YES / NO _____
- Have you ever had any prolonged bleeding? YES / NO _____
- Reason for your visit: _____

DO YOU HAVE (or HAVE YOU HAD) ANY OF THE FOLLOWING?

- AIDS/HIV Positive	YES / NO	- Diabetes	YES / NO	- Rheumatic Fever	YES / NO
- Anemia	YES / NO	- Drug Addiction	YES / NO	- Rheumatism	YES / NO
- Angina	YES / NO	- Epilepsy/Seizures	YES / NO	- Scarlet Fever	YES / NO
- Arthritis / Gout	YES / NO	- Heart Attack	YES / NO	- Sickle Cell Disease	YES / NO
- Artificial Heart Valve	YES / NO	- Heart Disease	YES / NO	- Sinus Trouble	YES / NO
- Artificial Joint	YES / NO	- Hepatitis (A, B or C)	YES / NO	- Stomach Disease	YES / NO
- Asthma	YES / NO	- High Blood Pressure	YES / NO	- Stroke	YES / NO
- Bruise Easily	YES / NO	- Leukemia	YES / NO	- Thyroid Disease	YES / NO
- Cancer	YES / NO	- Liver Disease	YES / NO	- Tonsilitis	YES / NO
- Chemotherapy	YES / NO	- Low Blood Pressure	YES / NO	- Tuberculosis	YES / NO
- Convulsions	YES / NO	- Mitral Valve Prolapse	YES / NO	- Tumors / Growths	YES / NO
				- Ulcers	YES / NO

Have you had, or do you have, any other conditions that are not listed here? YES / NO *(if so, please list on back)*

WOMEN ONLY, are you... - Pregnant/Trying? YES / NO - Nursing? YES / NO - Taking Oral Contraceptives? YES / NO

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE AND THAT THE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. ***IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.***

_____ _____

Signature of Patient (or Parent, if patient is a minor) **Date**

(Revised 8/17/2022~cr)