MIDLANDS DENTAL
WHERE CARING COUNTS

MEDICAL HISTORY

Patient Name ______________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	YES	NO	IF YES, PLEASE EXPLAIN:
Are you under a physician's care now?	☐	☐	
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Are you taking any medications pills, or drugs?	☐	☐	
Do you take, or have you taken, Phen-Fen or Redux?	☐	☐	
Are you on a special diet?	☐	☐	
Do you use tobacco?	☐	☐	
Do you use controlled substances?	☐	☐	
Do you need to premedicate?	☐	☐	

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No   Nursing? ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following? (check all) ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other (please explain) ______________________

Do you have or have you had any of the following medical conditions or procedures?

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain ______________________

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Comments ______________________

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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 changes in medical status.

Signature of Patient, Parent, or Guardian ______________________ Date ______________________