

Medical List 1-22-19 Updated

Patient Name:

Birth Date:

Date Created:

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? Who is your Physician or clinic?
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?
Have you been told you need to take a premedication for your dental appointments?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Anxiety/Depression Arthritis, OA/RA Artificial Heart Valve Artificial Joint(s) Asthma Blood Disease Blood Transfusion Breathing Problems Bruise Easily Cancer (Any Type) Chemotherapy/Radiation Chest Pains
Cholesterol Meds/"High" Cold Sores/Fever Blister Cortisone/Steroid Diabetes Drug/Alcohol Addiction Easily Winded Emphysema/COPD Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Diarrhea Frequent Headaches Glaucoma Gout Heart Attack/Failure
Heart Pace Maker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Irregular Heart Beat/AFib Kidney Problems Liver Disease Low Blood Pressure Lung Disease Osteopenia/Osteoporosis
Pain in Jaw Joints Parathyroid Issues Recent Weight Loss Rheumatic or Scarlet Fever Shingles Sinus Trouble Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis/Strep Throat Tuberculosis (TB) Tumors or Growths Ulcers Venereal Disease

Have you ever had any serious illness not listed above? If yes

Additional comments

Additional Comments If yes

To the best of my knowledge, the questions on this form have been accurately answered. Providing incorrect information can be dangerous to the patient's health. I will inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____

Date: _____