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 you will receive. Please answer the following completely.

Are you under a physicians care? If so, please explain_____

Are you on a special diet? ___Y ___ N Do you use tobacco? ___ Y ___ N

Do you use controlled substances? ___Y ___ N Do you take or have you taken, Phen-Fen or Redux? ___Y ___ N

Are You allergic to any of the following?

___ Aspirin ___ Penicillin ___ Codeine ___ Local Anesthetics ___ Acrylic ___ Metal ___ Latex ___ Sulfa drugs

___ Other : List_____

Have you ever been told you have HEREDITORY ANGIODEMA OR ACE INHIBITOR INDUCED ANGIODEMA? Y N

Do you take any of the following? If so please circle any that apply to you.

Accupril Aceon Aggrenox Altace Capoten Capozide Coumadin Ecotrin

Effient Hydrochlorothiazide Lisinopril Lotensin Mavik Monopril Plavix Prinivil Prinzide

Vaseret Vasotec Zestoretic Zestrill

Please list all your medications, including over the counter drugs:_____

_____

_____

Have you been hospitalized or had any operations? If so, please list::_____

_____

WOMEN ONLY:

Are you Pregnant/Trying to get pregnant? ___Y ___ N Nursing? ___Y ___N Taking oral contraceptives? ___Y ___N

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

AIDS/HIV	Y	N	Excessive Thirst	Y	N	Rheumatic Fev er	Y	N
Alzheimer's Disease	Y	N	Fainting Spells/Dizziness	Y	N	Rheumatism	Y	N
Anaphylaxis	Y	N	Frequest Headaches	Y	N	Scarlet Fever	Y	N
Anemia	Y	N	Gential Herpes	Y	N	Shingles	Y	N
Angina	Y	N	Glaucoma	Y	N	Sickle Cell Disease	Y	N
Arthritis/Gout	Y	N	Hay Fever	Y	N	Sinus Trouble	Y	N
Artificial Heart Valve	Y	N	Heart Attack/Failure	Y	N	Spina Bifida	Y	N
Artificial Joint	Y	N	Heart Murmur	Y	N	Stomach/Intestinal Disease	Y	N
Asthma	Y	N	Heart Pacemaker	Y	N	Stroke	Y	N
Blood Disease	Y	N	Heart Trouble/Disease	Y	N	Swelling of Limbs	Y	N
Blood Transfusion	Y	N	Hemophilia	Y	N	Thyroid Disease	Y	N
Breathing Problem	Y	N	Hepatitis A B or C	Y	N	Tonsillitis	Y	N
Bruise Easily	Y	N	Herpes	Y	N	Tuberculosis	Y	N
Cancer	Y	N	High Blood Pressure	Y	N	Tumors or Growths	Y	N
Chemotherapy	Y	N	High Cholesterol	Y	N	Ulcers	Y	N
Chest Pains	Y	N	Hives, Rash	Y	N	Venereal Disease	Y	N
Cold Sores/Fever Blisters	Y	N	Hypoglycemia	Y	N	Yellow Jaundice	Y	N
Congenital Heart Disorder	Y	N	Kidney Problems	Y	N			
Convulsions	Y	N	Leukemia	Y	N			
Cortisone Medicine	Y	N	Liver Disease	Y	N			
COPDE	Y	N	Mitral Valve Prolapse	Y	N			
Diabetes	Y	N	Osteoporosis	Y	N			
Drug Addiction	Y	N	Pain in Jaw Joints	Y	N			
Easily Winded	Y	N	{Parathyroid	Y	N			
Emphysema	Y	N	Radiation Treatments	Y	N			
Epilepsy or Seizures	Y	N	Recent Weight Loss	Y	N			
Excessive Bleeding	Y	N	Renal Dialysis	Y	N			

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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 any changes in Medical Status.

_____

Signature of patient, parent or guardian Date