

Lake Baldwin Dental
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. Thank you for answering the following questions.

Are you under a physician's care now? 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 _____

Are you taking any medications, pills, or drugs? Yes No _____

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?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Local Anesthetics

Acrylic

Metal

Latex

Other

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

AIDS/HIV Positive

Chest Pains

Frequent Headaches

Irregular Heartbeat

Scarlet Fever

Alzheimer's Disease

Cold Sores/Fever Blisters

Genital Herpes

Kidney Problems

Shingles

Anaphylaxis

Congenital Heart Disorder

Glaucoma

Leukemia

Sickle Cell Disease

Anemia

Convulsions

Hay Fever

Liver Disease

Sinus Trouble

Angina

Cortisone Medicine

Heart Attack/Failure

Low Blood Pressure

Spina Bifida

Arthritis/Gout

Diabetes

Heart Murmur

Lung Disease

Stomach/Intestinal Disease

Artificial Heart Valve

Drug Addiction

Heart Pace Maker

Mitral Valve Prolapse

Stroke

Artificial Joint

Easily Winded

Heart Trouble/Disease

Pain in Jaw Joints

Swelling of Limbs

Asthma

Emphysema

Hemophilia

Parathyroid Disease

Thyroid Disease

Blood Disease

Epilepsy or Seizures

Hepatitis A

Psychiatric Care

Tonsillitis

Blood Transfusion

Excessive Bleeding

Hepatitis B or C

Radiation Treatments

Tuberculosis

Breathing Problem

Excessive Thirst

Herpes

Recent Weight Loss

Tumors or Growths

Bruise Easily

Fainting Spells/Dizziness

High Blood Pressure

Renal Dialysis

Ulcers

Cancer

Frequent Cough

Hives or Rash

Rheumatic Fever

Venereal Disease

Chemotherapy

Frequent Diarrhea

Hypoglycemia

Rheumatism

Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No

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 _____