Medical History

For

Patient's name _____ Date _____

Although dental personnel primarily treat the area in and around the 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.

	Yes	No	If yes, please explain
Are you under a physican'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?	☐	☐	

Women, are you:

☐ Pregnant/trying to get pregnant?
☐ Taking oral contraceptives?
☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local anesthetics ☐ Other If yes, please explain: _____

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

☐ AIDS?HIV positive	☐ Cancer	☐ Excessive thirst	☐ Hepatitis A
☐ Alzheimer's Disease	☐ Chemotherapy	☐ Fainting spells/Dizziness	☐ Hepatitis B or C
☐ Anaphylaxis	☐ Chest pains	☐ Frequent cough	☐ Herpes
☐ Anemia	☐ Cold sores/Fever blisters	☐ Frequent diarrhea	☐ High blood pressure
☐ Angina	☐ Congenital heart disease	☐ Frequent headaches	☐ Hives or rash
☐ Arthritis/Gout	☐ Convulsions	☐ Genital herpes	☐ Hypoglycemia
☐ Artificial heart valve	☐ Cortisone medication	☐ Glaucoma	☐ Irregular heartbeat
☐ Artificial joint	☐ Diabetes	☐ Hay fever	☐ Kidney problems
☐ Asthma	☐ Drug addiction	☐ Heart attack/failure	☐ Leukemia
☐ Blood disease	☐ Easily winded	☐ Heart murmur	☐ Liver disease
☐ Blood transfusion	☐ Emphysema	☐ Heart pacemaker	☐ Low blood pressure
☐ Breathing problem	☐ Epilepsy or Seizures	☐ Heart trouble/disease	☐ Lung disease

☐ Bruise easily	☐ Excessive bleeding	☐ Hemophillia	☐ Mitral valve prolapse
☐ Pain in jaw joints	☐ Rheumatic fever	☐ Spina bifida	☐ Tuberculosis
☐ Parathyroid disease	☐ Rheumatism	☐ Stomach/intestinal disease	☐ Tumors or growths
☐ Psychiatric care	☐ Scarlet fever	☐ Stroke	☐ Ulcers
☐ Radiation treatments	☐ Shingles	☐ Swelling of limbs	☐ Veneral disease
☐ Recent weight loss	☐ Sickle cell disease	☐ Thyroid disease	☐ Yellow jaundice
☐ Renal dialysis	☐ Sinus trouble	☐ Tonsilitis	

Have you ever had a serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

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 responsibilty to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian *Date*

David W. Hammer, DMD, PSC
3413 Stony Spring Circle
Louisville, KY 40220
502.499.8827