Staffordshire Dental Group, PA

MEDICAL HISTORY

PATIENT NAME ______________________________________Birth Date__________________________________

ADDRESS: ____TELEPHONE #'S: ___________________________

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	If yes, please explain: ______
Have you ever been hospitalized or had a major operation?	☐Yes	☐No	If yes, please explain: ______
Have you ever had a serious head or neck injury?	☐Yes	☐No	If yes, please explain: ______
Are you taking any medications, pills, or drugs?	☐Yes	☐No	If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux?	☐Yes	☐No	If yes, please explain: ______
Are you on a special diet?	☐Yes	☐No	If yes, please explain: ______
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? 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
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Brood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cholesterol (High)
- ☐ Cold Sores/ Fever Blisters
- ☐ Congestive Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Heart Murmur
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ 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 Heartbeat
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Radiation Treatments
- ☐ Mitral Valve Prolapse
- ☐ Pain Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spinal Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors of Growths
- ☐ Venereal Disease
- ☐ Yellow Jaundice

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 ________________