Time 8:50 AM

Leon County Health Department

Medical History

Date 2/1/2016

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 allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Are you under a physician's care now? ○ Yes ○ No If yes

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes

Are you on a special diet? ○ Yes ○ No If yes

Do you use tobacco? ○ Yes ○ No If yes

Do you use controlled substances? ○ Yes ○ No If yes

Women: Are you

☐ Pregnancy/Trying to get pregnant ☐ Taking Oral Contraceptives ☐ Nursing

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Diabetes I or II ○ Yes ○ No
Hepatitis A, B or C ○ Yes ○ No	Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Herpes ○ Yes ○ No	Angina ○ Yes ○ No	High Blood Pressure ○ Yes ○ No
Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No
Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No	Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No
Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No	Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No
Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No
Spina Bifida ○ Yes ○ No	Blood Transfusion ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No
Swelling of Limbs ○ Yes ○ No	Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No
Thyroid Disease ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No
Tonsillitis ○ Yes ○ No	Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No
Tuberculosis ○ Yes ○ No	Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No
Tumors or Growths ○ Yes ○ No	Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No
Ulcers ○ Yes ○ No	Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No
Venereal Disease ○ Yes ○ No			

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

☐ ADD/ADHD ☐ Autism ☐ Developmental Delay

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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:

X Date:_____