**David P. Young, D.M.D.,DICOI**

# MEDICAL HISTORY

Patient's First Name: _____Last Name_____Middle Initial _____Date of Birth_____

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? ___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 medication pills or drugs? ___Yes ___No If yes, please explain: _____

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? ☐___Yes ___ No Taking oral contraceptives? ____ Yes ____No Nursing? ____Yes ____No

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 | __Yes ___No | Cortisone Medicine | ___Yes ___No | Hemophilia | ___Yes ___No | Renal Dialynis | ___Yes ___No |
| Alzheimer's Disease | __Yes ___No | Diabetes | ___Yes ___No | Hepatitis A | ___Yes ___No | Rheumatic Fever | ___Yes ___No |
| Anaphylaxis | __Yes ___No | Drug Addition | ___Yes ___No | Hepatitis B or C | ___Yes ___No | Rheumatism | ___Yes ___No |
| Anemia | __Yes ___No | Easily Winded | ___Yes ___No | Herpes | ___Yes ___No | Scarlet Fever | ___Yes ___No |
| Angina | __Yes ___No | Emphysema | ___Yes ___No | High Blood Pressure | ___Yes ___No | Shingles | ___Yes ___No |
| Arthritis/Gout | __Yes ___No | Epilepsy or Seizures | ___Yes ___No | Hives or Rash | ___Yes ___No | Sickle Cell Disease | ___Yes ___No |
| Artificial Heart Valve | __Yes ___No | Excessive Bleeding | ___Yes ___No | Hypoglycemia | ___Yes ___No | Sinus Trouble | ___Yes ___No |
| Artificial Joint | __Yes ___No | Excessive Thirst | ___Yes ___No | Irregular Heartbeat | ___Yes ___No | Spina Bifida | ___Yes ___No |
| Asthma | __Yes ___No | Fainting Spells/Dizziness | ___Yes ___No | Kidney Problems | ___Yes ___No | Stomach/Intestinal Disease | ___Yes ___No |
| Blood Disease | __Yes ___No | Frequent Cough | ___Yes ___No | Leukemia | ___Yes ___No | Stroke | ___Yes ___No |
| Blood Transfusion | __Yes ___No | Frequent Diarrhea | ___Yes ___No | Liver Disease | ___Yes ___No | Swelling of Limbs | ___Yes ___No |
| Breathing Problem | __Yes ___No | Frequent Headaches | ___Yes ___No | Low Blood Pressure | ___Yes ___No | Thyroid Disease | ___Yes ___No |
| Bruise Easily | __Yes ___No | Genital Herpes | ___Yes ___No | Lung Disease | ___Yes ___No | Tonsillitis | ___Yes ___No |
| Cancer | __Yes ___No | Glaucoma | ___Yes ___No | Mitral Valve Prolapse | ___Yes ___No | Tuberculosis | ___Yes ___No |
| Chemotherapy | __Yes ___No | Hay Fever | ___Yes ___No | Pain in Jaw Joints | ___Yes ___No | Tumors or Growths | ___Yes ___No |
| Chest Pains | __Yes ___No | Heart Attack/Failure | ___Yes ___No | Parathyroid Disease | ___Yes ___No | Ulcers | ___Yes ___No |
| Cold sores/Fever Blisters | __Yes ___No | Heart Murmur | ___Yes ___No | Psychiatric Care | ___Yes ___No | Venereal Disease | ___Yes ___No |
| Congenital Heart Disorder | __Yes ___No | Heart Pace Maker | ___Yes ___No | Radiation Treatment | ___Yes ___No | Yellow Jaundice | ___Yes ___No |
| Convulsions | __Yes ___No | Heart Trouble/Disease | ___Yes ___No | Recent Weight Loss | ___Yes ___No | | |

Have you ever had any serious illness not listed above? ____Yes ____No If Yes Please explain: _____

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.

Comments _____

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_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____DATE_____