Citrus Dental Medical History

Patient Name:
Birth Date:

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? _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 taking any medications, pills, or drugs? _yes _no If yes ______________________
Do you take, or have you taken, Phen-Fen or Redux? _yes _no If yes ______________________
Have you ever taken ANY oral, injectable, or IV medication for osteoporosis? _yes _no If yes ______________________
Do you use tobacco? _yes _no If yes ______________________
Do you use controlled substances? _yes _no If yes ______________________

Women: Are you. . .
__ Pregnant/Trying to get pregnant __ Nursing? __ Taking Oral Contraceptives?

Are you allergic to any of the following?
__ Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex __ Sulfa Drugs __ Local Anesthetics
__ Other

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

AIDS/HIV Positive	_yes _no	Excessive Thirst	_yes _no	Mitral Valve Prolapse	_yes _no
Altzheimer's Disease	_yes _no	Fainting Spells/Dizziness	_yes _no	Osteoporosis	_yes _no
Anaphylaxis	_yes _no	Frequent Cough	_yes _no	Pain in Jaw Joints	_yes _no
Anemia	_yes _no	Frequent Diarrhea	_yes _no	Parathyroid Disease	_yes _no
Angina	_yes _no	Frequent Headaches	_yes _no	Psychiatric Care	_yes _no
Arthritis/Gout	_yes _no	Genital Herpes	_yes _no	Radiation Treatment	_yes _no
Artificial Heart Valve	_yes _no	Glaucoma	_yes _no	Reecnt Weight Loss	_yes _no
Artificial Joint	_yes _no	Hay Fever	_yes _no	Renal Dialysis	_yes _no
Asthma	_yes _no	Heart Attack/Failure	_yes _no	Rheumatic Fever	_yes _no
Blood Disease	_yes _no	Heart Murmur	_yes _no	Rheumatism	_yes _no
Blood Transfusion	_yes _no	Heart Pacemaker	_yes _no	Scarlet Fever	_yes _no
Breathing Problems	_yes _no	Heart Trouble/Disease	_yes _no	Shingles	_yes _no
Bruise Easily	_yes _no	Hemophilia	_yes _no	Sickle Cell Disease	_yes _no
Cancer	_yes _no	Hepatitis A	_yes _no	Sinus Trouble	_yes _no
Chemotherapy	_yes _no	Hepatitis B or C	_yes _no	Spina Bifida	_yes _no
Chest Pains	_yes _no	Herpes	_yes _no	Stomach/Intestinal Dise	_yes _no
Cold Sores/Fever Blister	_yes _no	High Blood Pressure	_yes _no	Stroke	_yes _no
Congenital Heart Disord	_yes _no	High Cholesterol	_yes _no	Swelling of Limbs	_yes _no
Convulsions	_yes _no	Hives or Rash	_yes _no	Thyroid Disease	_yes _no
Cortisone Medicine	_yes _no	Hypoglycemia	_yes _no	Tonsillitis	_yes _no
Diabetes	_yes _no	Irregular Heart Beat	_yes _no	Tuberculosis	_yes _no
Drug Addiction	_yes _no	Kidney Problems	_yes _no	Tumors or Growths	_yes _no
Easily Winded	_yes _no	Leukemia	_yes _no	Ulcers	_yes _no
Emphysema	_yes _no	Liver Disease	_yes _no	Venereal Disease	_yes _no
Epilepsy/Seizures	_yes _no	Low Blood Pressure	_yes _no	Yellow Jaundice	_yes _no
Excessive Bleeding	_yes _no	Lung Disease	_yes _no		

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 the 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: ______________