

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dental care you receive. Thank you for answering the following questions.

Have you ever been told to **pre-medicate** for dental treatment? Yes No

Are you under a physician's care now? Yes No Name of Physician _____

Have you ever been hospitalized or had a major operation? Yes No _____

Do you use tobacco? Yes No **Women:** Are you pregnant/ Trying to get pregnant ? Yes No

Nursing Yes No Taking oral contraceptives? Yes No

Do you have, or have you had, any of the following? (*Check only those that apply*)

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sore/Fever Blister | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Yellow Jaundice |

***Condition may require Pre-medication**

Have you ever had any serious illness not listed above? Yes No _____

MEDICATIONS	ALLERGIES
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LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

LIST ALL DRUG ALLERGIES

Aspirin

Penicillin

Sulfa

Latex

Codeine

Local Anesthetics

Other _____

Pharmacy _____

Location _____

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 Tompkins Family Dental of any changes in medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT,PARENT,GUARDIAN

DATE