JAQS DENTAL ARTS STUDIO

MEDICAL HISTORY

PATIENT NAME _____Birth Date _____

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, explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	If yes, explain: _____
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes, explain: _____
Are you taking any medications, pills, or drugs?	◯ Yes	◯ No	If yes, explain: _____
Are you on a special diet?	◯ Yes	◯ No	If yes, explain: _____
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 ◯ Local Anesthetics ◯ Acrylic ◯ Metal
◯ Latex ◯ Sulfa drugs ◯ Other, If yes, please explain: _____

Do you have, or have you had, any of the following? (Fill the table if) YES ☐ **NO:** ☐

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

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

Comments: _____

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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 _____