

PATIENT MEDICAL HISTORY

WESTON DENTAL • Leah Weston, DDS • Jean Kim, DDS
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Patient Name: _____ Patient Birthdate: _____

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, 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 medications, 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
Do you need to pre-medicate? Yes No If yes, please explain: _____

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 Dialysis Yes No
Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Rheumatic Fever Yes No
Anaphylaxis Yes No Drug Addiction 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 Treatments 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: _____

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 _____ DATE _____