CHESAPEAKE SMILES
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, 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

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? Please circle Yes and draw a line through No.

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			

Are there any special needs we should be aware of? No Yes, _____

Have you ever had any 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** _____

SIGNATURE OF DENTIST _____ **DATE** _____