MEDICAL HISTORY

Lindale Dental
CARE | COMFORT | CONVENIENCE

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. If no, please type N/A below

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

If yes, please explain. If no, please type N/A below

Have you ever had a serious head or neck injury?
Yes No

If yes, please explain. If no, please type N/A below

Are you taking any medications, pills, or drugs?
Yes No

If yes, please explain. If no, please type N/A below

Gender
Male Female Other

Do you take, or have you taken, Phen-Fen or Redux?
Yes No

Do you take, or have you taken a bisphosphonate (anit-bone resorption medication)
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. If no, please type N/A below

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

If yes, please explain. If no, please type N/A below

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

AIDS/HIV Positive ○ Yes ○ No

Alzheimer's Disease ○ Yes ○ No

Anaphylaxis ○ Yes ○ No

Anemia ○ Yes ○ No

Angina ○ Yes ○ No

Arthritis/Gout ○ Yes ○ No

Artificial Heart Valve ○ Yes ○ No

Artificial Joint ○ Yes ○ No

Asthma ○ Yes ○ No

Blood Disease ○ Yes ○ No

Blood Transfusion ○ Yes ○ No

Breathing Problem ○ Yes ○ No

Bruise Easily ○ Yes ○ No

Cancer ○ Yes ○ No

Chemotherapy ○ Yes ○ No

Chest Pains ○ Yes ○ No

Cold Sores/Fever Blisters ○ Yes ○ No

Congenital Heart Disorder ○ Yes ○ No

Convulsions ○ Yes ○ No

Cortisone Medicine ○ Yes ○ No

Diabetes ○ Yes ○ No

Drug Addiction ○ Yes ○ No

Easily Winded ○ Yes ○ No

Emphysema ○ Yes ○ No

Epilepsy or Seizures ○ Yes ○ No

Excessive Bleeding ○ Yes ○ No

Excessive Thirst ○ Yes ○ No

Fainting Spells/Dizziness ○ Yes ○ No

Frequent Cough ○ Yes ○ No

Frequent Diarrhea ○ Yes ○ No

Frequent Headaches ○ Yes ○ No

Genital Herpes ○ Yes ○ No

Glaucoma ○ Yes ○ No

Hay Fever ○ Yes ○ No

Heart Attack/Failure ○ Yes ○ No

Heart Murmur ○ Yes ○ No

Heart Pacemaker ○ Yes ○ No

Heart Trouble/Disease ○ Yes ○ No

Hemophilia ○ Yes ○ No

Hepatitis A ○ Yes ○ No

Hepatitis B or C ○ Yes ○ No

Herpes ○ Yes ○ No

High Blood Pressure ○ Yes ○ No

Hives or Rash ○ Yes ○ No

Hypoglycemia ○ Yes ○ No

Irregular Heartbeat ○ Yes ○ No

Kidney Problems ○ Yes ○ No

Leukemia ○ Yes ○ No

Liver Disease ○ Yes ○ No

Low Blood Pressure ○ Yes ○ No

Lung Disease ○ Yes ○ No

Mitral Valve Prolapse ○ Yes ○ No

Pain in Jaw Joints ○ Yes ○ No

Parathyroid Disease ○ Yes ○ No

Psychiatric Care ○ Yes ○ No

Radiation Treatments ○ Yes ○ No

Recent Weight Loss ○ Yes ○ No

Renal Dialysis ○ Yes ○ No

Rheumatic Fever ○ Yes ○ No

Rheumatism ○ Yes ○ No

Scarlet Fever ○ Yes ○ No

Shingles ○ Yes ○ No

Sickle Cell Disease ○ Yes ○ No

Sinus Trouble ○ Yes ○ No

Spina Bifida ○ Yes ○ No

Stomach/Intestinal Disease ○ Yes ○ No

Stroke ○ Yes ○ No

Swelling of Limbs ○ Yes ○ No

Thyroid Disease ○ Yes ○ No

Tonsillitis ○ Yes ○ No

Tuberculosis ○ Yes ○ No

Tumors or Growths ○ Yes ○ No

Ulcers ○ Yes ○ No

Venereal Disease ○ Yes ○ No

Yellow Jaundice ○ Yes ○ No

Osteoporosis ○ Yes ○ No

○ No to all medical conditions

Have you ever had any serious illness not listed above?

Yes No

If yes, please explain. If no, please type N/A below

Comments

Signature of Patient, Parent or Guardian

Date