100 W. Southlake Blvd.
Suite-146
Southlake, TX 76051
(817)251-9333
www.davincidentistry.com

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	If yes, please explain: _____
Are you on a special diet?	Yes	No	If yes, please explain: _____
Do you use tobacco?	Yes	No	If yes, please explain: _____
Do you use controlled substances?	Yes	No	If yes, please explain: _____
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? (Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please list: _____

Do you have, or have you had, any of the following? (Circle)

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

Have you ever had any serious illness not listed above? If yes, please list: _____

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 _____