Berkeley Lake Dental
MEDICAL HISTORY

Last Name: _____First _____ MI. _____ Date of Birth: _____

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__ Nursing? Yes __ No __ Taking Birth Control ? Yes__ No

Are you allergic to the followings?
Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Local anesthetic ___ Other _____

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

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

Have you ever had any serious illness not listed above? Yes __ No __. If yes, please explain: _____

_____

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 (patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of patient, parent, or guardian_____ Date _____