NEW ERA
FAMILY & COSMETIC DENTISTRY

Medical History

Patient Name _____ *Birth Date*_____

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?

Have you ever been hospitalized or had major operation?

Have you ever had a serious neck injury?

Are you taking any medications, pills, or drugs?

Do you use tobacco products?

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 ○Local Anesthesia ○Acrylic ○Metal
○Latex ○Sulfa Drugs ○Other If yes, please explain: _____

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

AIDS/HIV Positive	○ YES ○NO	Hay Fever	○YES ○NO	Rheumatism	○YES ○NO
Alzheimer's disease	○ YES ○NO	Heart Attack/ Failure	○YES ○NO	Sinus Problems	○YES ○NO
Anemia	○YES ○NO	Heart Disease	○YES ○NO	Stomach Disease	○YES ○NO
Asthma	○YES ○NO	Heart Murmur	○YES ○NO	Stroke	○YES ○NO
Artificial Joints	○YES ○NO	Hepatitis A	○YES ○NO	Ulcers	○YES ○NO
Blood Disease	○YES ○NO	Hepatitis B or C	○YES ○NO	Venereal Disease	○YES ○NO
Cancer	○YES ○NO	Herpes	○YES ○NO	Yellow Jaundice	○YES ○NO
Chemotherapy	○YES ○NO	High Blood Pressure	○YES ○NO	Other:	○
Cold Sores/ Fever Blisters	○YES ○NO	Kidney Disease	○YES ○NO	_____	
Congenital Heart Disorder	○YES ○NO	Liver Disease	○YES ○NO	NONE OF THE ABOVE	○
Diabetes	○YES ○NO	Low Blood Pressure	○YES ○NO		
Epilepsy	○YES ○NO	Mental Disorder	○YES ○NO		
Excessive Bleeding	○YES ○NO	Nervous Disorder	○YES ○NO		
Fainting/Dizzy Spells	○YES ○NO	Pain in Jaw	○YES ○NO		
Frequent Headaches	○YES ○NO	Rheumatic Fever	○YES ○NO		

Have you ever had any serious illness not listed above? _____

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 _____