Ohio Hills Health Centers

Barnesville Dental Center
Freeport Dental Center

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, explain_____
Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, explain_____
Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, explain_____
Are you taking any medications, pills, or drugs? ☐Yes ☐No If yes, list _____

Are you on a special diet? ☐Yes ☐No If yes, explain_____
Do you use tobacco? ☐Yes ☐No if yes, explain_____
Women: Are you ☐Pregnant/trying to get pregnant? ☐Nursing? ☐Taking oral contraceptives?
Are you allergic to any of the following?
☐Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐Other - _____

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐No If yes, 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**_____