MAIN STREET DENTAL
your main address for gentle convenient care

Health History

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.

Name (first and last) * _____

Date of Birth *_____

Are you under a physician's care now?
- ☐ Yes
- ☐ No

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

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

Are you taking any medication, pills, or drugs?
- ☐ Yes
- ☐ No

Please list any medications, pills, or drugs:

_____

_____

_____

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

Are you on a special diet?
- ☐ Yes
- ☐ No

Do you use controlled substances?
- ☐ Yes
- ☐ No

Do you use tobacco products?
- ☐ Yes
- ☐ No

Women: Are you pregnant/trying to get pregnant?
- ☐ Yes
- ☐ No

Women: Are you taking oral contraceptives?

- ☐ Yes
- ☐ No

Women: Are you nursing?

- ☐ Yes
- ☐ No

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codiene
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Local Anesthetics

If you have, or have had, any of the following please check:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Angina
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital 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 Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Comments_____

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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 _____ Date _____