

FULTON COUNTY HEALTH DEPARTMENT DENTAL CENTER  
**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

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:

Are you under a physician's care now? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? Y \_\_\_\_\_ N \_\_\_\_\_

Do you have any screws, pins, plates, artificial valves, etc. Y \_\_\_\_\_ N \_\_\_\_\_

in your body? If yes, please explain? \_\_\_\_\_

Are you taking any medications, pills, or drugs? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Do you take or have you taken Phen-Fen, Redux, or Y \_\_\_\_\_ N \_\_\_\_\_

Fosamox? I

Are you on a special diet? Y \_\_\_\_\_ N \_\_\_\_\_

Do you use tobacco? Y \_\_\_\_\_ N \_\_\_\_\_

Do you use controlled substances? Y \_\_\_\_\_ N \_\_\_\_\_

Women: Are you ----- Pregnant/trying to get pregnant Y \_\_\_\_\_ N \_\_\_\_\_

Taking oral contraceptives Y \_\_\_\_\_ N \_\_\_\_\_

Nursing Y \_\_\_\_\_ N \_\_\_\_\_

Are you allergic to any of the following:

Aspirin \_\_\_\_\_ Penicillin \_\_\_\_\_ Codeine \_\_\_\_\_ Acrylic \_\_\_\_\_ Metal \_\_\_\_\_ Latex \_\_\_\_\_

Local Anesthetics \_\_\_\_\_ Other (please list): \_\_\_\_\_

**PLEASE CONTINUE ON BACKSIDE FOR LIST OF ILLNESSES**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_