

FULTON COUNTY HEALTH DEPARTMENT DENTAL CENTER :MEDICAL HISTORY

Patient Name: _____

Birthdate: _____

Dr Name: _____

Dr. Phone _____

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. in your body? Y _____ N _____
If yes, please explain?

Are you taking any medications, pills, or drugs? Please list all medications currently being taken and why. Please include all Over-the-Counter meds such as vitamins/minerals. Y _____ N _____

Do you take or have you taken Phen-Fen, Redux, or Fosamox? Y _____ N _____

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

Revised 08/2010

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

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

Have you ever had any serious illness not listed above? Y__N 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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature & Date _____