Dr Denise Perrotta, DMD DATE

MEDICAL HISTORY

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, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
Are you on a special diet? Yes No _____
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Renal Dialysis Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Rheumatic Fever Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Rheumatism Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Scarlet Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Shingles Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	Hives or Rash Yes No	Sickle Cell Disease Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hypoglycemia Yes No	Sinus Trouble Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Irregular Heartbeat Yes No	Spina Bifida Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Kidney Problems Yes No	Stomach/Intestinal Disease Yes No
Blood Disease Yes No	Frequent Cough Yes No	Leukemia Yes No	Stroke Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Liver Disease Yes No	Swelling of Limbs Yes No
Breathing Problem Yes No	Frequent Headaches Yes No	Low Blood Pressure Yes No	Thyroid Disease Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Lung Disease Yes No	Tonsillitis Yes No
Cancer Yes No	Glaucoma Yes No	Mitral Valve Prolapse Yes No	Tuberculosis Yes No
Chemotherapy Yes No	Hay Fever Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
Congenital Heart Disorder Yes No	Heart Pace Maker Yes No	Radiation Treatments Yes No	Yellow Jaundice Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Recent Weight Loss Yes No	

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 OF PATIENT, PARENT, or GUARDIAN _____ DATE _____