The Village Dentist

MEDICAL HISTORY

FOR

Birth Date:

Are you under a physician's care now? Yes No ave 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				f yes, please explain:			
Do you take, or have you taken, Phen-Fen or Redux? Yes No							
		u on a special diet? 🔘 Yes 🔘					
		o you use tobacco? 🔘 Yes 🤇					
	Do you use con	trolled substances? 🔘 Yes 🔘	No				
Nomen: Are you ─ Pregnant/Trying to g	get pregnant?	Yes No Taking oral co	ntracep	otives? O Yes O No	Nursing?	Yes No	
Are you allergic to a	any of the followin	g?			***************************************		
Aspirin Other If yes, p	Penicillin [lease explain:	Codeine Acrylic		Netal Latex	Local	Anesthetics	
	•						***************************************
Do you have, or hav			/ Na	L Homophilia	Yes () No	Renal Dialysis	
DS/HIV Positive zheimer's Disease	Yes No Yes No No	Cortisone Medicine Yes Diabetes Yes	O No		Yes No	Rheumatic Fever	O Yes O N
naphylaxis	Yes No	Drug Addiction Yes	-		Yes No	Rheumatism	Ŏ Yes Ŏ N
nemia	○ Yes ○ No	Easily Winded Yes	~		Yes No	Scarlet Fever	Yes O
ngina	○ Yes ○ No	Emphysema Yes	~		Yes Ŏ No	Shingles	
thritis/Gout	Ŏ Yes Ŏ No	Epilepsy or Seizures Yes	Ŏ No	Hives or Rash O	Yes 🔘 No	Sickle Cell Disease	○ Yes ○ I
tificial Heart Valve	O Yes O No	Excessive Bleeding Yes	O No	Hypoglycemia (Yes O No	Sinus Trouble	Yes ()
rtificial Joint	○ Yes ○ No	Excessive Thirst Yes	-	3	∕es ◯ No	Spina Bifida	Yes () N
sthma	Yes No	Fainting Spells/Dizziness Yes	~	×	res No	Stomach/Intestinal Disease	A
ood Disease	○ Yes ○ No	Frequent Cough Yes	~	<u> </u>	∕es () No	Stroke	Yes () N
ood Transfusion	○ Yes ○ No	Frequent Diarrhea Yes	_		/es ○ No	Swelling of Limbs	Yes O M
reathing Problem	○ Yes ○ No	Frequent Headaches Yes	~	<u> </u>	/es ○ No	Thyroid Disease Tonsillitis	Yes O N
ruise Easily	○ Yes ○ No	Genital Herpes Yes Glaucoma Yes	-	× ×	/es () No /es () No	Tuberculosis	O Yes O N
ancer hemotherapy		Glaucoma Yes Hay Fever Yes	~		res O No	Tumors or Growths	O Yes O N
hest Pains	Yes No	Heart Attack/Failure Yes	~	1 3	res No	Ulcers	O Yes O N
old Sores/Fever Bliste	× ×		O No		res O No	Venereal Disease	O Yes O N
			O No	Radiation Treatments (res 💍 No	Yellow Jaundice	Yes ○ N
onvulsions	O Yes O No	Heart Trouble/Disease Yes	O No	Recent Weight Loss ()	res O No		
Have you ever had	l any serious illne	ss not listed above? Yes	No If	yes, please explain:			
Comments:							
To the best of my k	knowledge, the qu	estions on this form have been	accura	tely answered. I understa	nd that prov	riding incorrect information	n can be
dangerous to my (or patient's) healt	h. It is my responsibility to infor	m the d	lental office of any change	s in medica	i status.	