MEDICAL HISTORY

NAME ____ ***Birth Date*** ______________________________

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(Address) (City, State and Zip Code)

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(Phone Numbers - Home) (Work) (Cell)

Dental personnel primarily treat the area in and around the mouth. However, as your mouth is part of your entire body, health problems that you may have, or medications 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 had a hospitalization in the last year? 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 list: ______________________________

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Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you allergic to any of the following?

Aspirin Yes No Penicillin Yes No Codeine Yes No Local Anesthetics Yes No Other _______________

Do you have or have you had:

Cancer Yes No Type: ____________________ Date: ______________________________

Radiation Yes No Date: ____________________ Chemo: Date: ______________________

Stents Yes No Date: ____________________

Women Only: Are you Pregnant/Trying to get pregnant? Yes No Nursing? Yes No

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

Acid Reflex	Yes No	Emphysema	Yes No	Liver Disease	Yes No
AIDS/HIV positive	Yes No	Epilepsy or Seizures	Yes No	Low Blood Pressure	Yes No
Alzheimer's Disease	Yes No	Excessive Bleeding	Yes No	Lung Disease/COPD	Yes No
Anemia	Yes No	Excessive Thirst	Yes No	Mitral Valve Prolapse	Yes No
Arthritis/Gout	Yes No	Fainting Spell/Dizziness	Yes No	Psychiatric Care	Yes No
Artificial Heart Valve	Yes No	Frequent Cough	Yes No	Renal Dialysis	Yes No
Artificial Joint	Yes No	Frequent Headaches	Yes No	Rheumatic Fever	Yes No
Asthma	Yes No	Heart Attack/Failure	Yes No	Shingles	Yes No
Blood Disease	Yes No	Heart Pace Maker	Yes No	Sickle Cell Disease	Yes No
Blood Transfusion	Yes No	Heart Disease	Yes No	Sinus Trouble	Yes No
Breathing Problem	Yes No	Hepatitis A, B, C	Yes No	Spina Bifida	Yes No
Chest Pains	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Congenital		Hives or Rash	Yes No	Thyroid Disease	Yes No
Heart Disorder	Yes No	Hypoglycemia	Yes No	TMJ Disorder	Yes No
Cortisone Medicine	Yes No	Kidney Disease	Yes No	Tuberculosis	Yes No
Diabetes	Yes No	Leukemia	Yes No	Tumors or Growths	Yes No

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

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Dr. Haddican's office requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. 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.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ______________________________ DATE: ______________