GREENVILLE FAMILY DENTISTRY

MEDICAL HISTORY

First Name: _____ Last Name: _____ M. Initial: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that 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: _____
Do you take or have you taken Phen-Fen or Redux?	☐ YES	☐ NO	If yes, please explain: _____
Are you on a special diet?	☐ YES	☐ NO	If yes, please explain: _____
Do you use tobacco?	☐ YES	☐ NO	If yes, please explain: _____
Do you use controlled substances?	☐ YES	☐ NO	If yes, please explain: _____
Are you taking any medications, supplements or vitamins?	☐ YES	☐ NO	Please list ALL: _____

Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex
☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa
☐ Other Explain: _____

Females:

Pregnant? Trying to get pregnant? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

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

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

Have you ever had a serious illness not listed above? ☐ YES ☐ NO

If yes, please explain: _____

Comments: _____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____ _____

Signature of Patient (parent or legal guardian if minor) Today's Date

*920 South Batesville Road, Greer, SC 29650 * Office (864) 877-9111 * www.greenvillefamilydentistrysc.com*