DLSDDS
STOLZENBURG
FAMILY & COSMETIC
DENTISTRY

MEDICAL HISTORY
FOR

Birth date:

Although we provide oral healthcare, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could adversely affect your oral health.
Thank you for answering the following questions.

	YES	NO	
Are you under a physician's care?	○	○	If yes, please explain
Have you ever been hospitalized or had a major operation?	○	○	If yes, please explain
Have you ever had a serious head or neck injury?	○	○	If yes, please explain
Do you take, or have you taken, Phen-Fen or Redux?	○	○	If yes, please explain
Are you on a special diet?	○	○	If yes, please explain
Do you use tobacco?	○	○	If yes, how much?
Do you use alcohol?	○	○	If yes,how often?
Do you use controlled substances?	○	○	If yes, please explain
Are you taking any medications?	○	○	If yes, please list all

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 ☐ Acryllic ☐ 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		Cold Sores/Fever Blisters	○ Yes	○ No	
Alhzheimer's Disease	○ Yes	○ No		Congenital Heart Disorder	○ Yes	○ No	
Anaphylaxis	○ Yes	○ No		Convulsions	○ Yes	○ No	
Anemia	○ Yes	○ No		Cortisone Medicine	○ Yes	○ No	
Angina	○ Yes	○ No		Diabetes	○ Yes	○ No	
Arthritis/Gout	○ Yes	○ No		Drug Addiction	○ Yes	○ No	
Artificial Heart Valve	○ Yes	○ No		Easily Winded	○ Yes	○ No	
Asthma	○ Yes	○ No		Emphysema	○ Yes	○ No	
Blood Disease	○ Yes	○ No		Epilepsy or Seizures	○ Yes	○ No	
Blood Transfusion	○ Yes	○ No		Excessive Bleeding	○ Yes	○ No	
Breathing Problem	○ Yes	○ No		Excessive Thirst	○ Yes	○ No	
Bruise Easily	○ Yes	○ No		Fainting Spells/Dizziness	○ Yes	○ No	
Cancer	○ Yes	○ No		Frequent Cough	○ Yes	○ No	
Chemotherapy	○ Yes	○ No		Frequent Diarrhea	○ Yes	○ No	
Chest Pains	○ Yes	○ No		Frequent Headaches	○ Yes	○ No	

Genital Herpes	○	Yes	◉	No	Pain in Jaw Joint	○	Yes	◉	No
Glaucoma	○	Yes	◉	No	Parathyroid Disease	○	Yes	◉	No
Hay Fever	○	Yes	◉	No	Psychiatric Care	○	Yes	◉	No
Heart Attack/Failure	○	Yes	◉	No	Radiation Treatments	○	Yes	◉	No
Heart Murmur	○	Yes	◉	No	Recent Weight Loss	○	Yes	◉	No
Heart Pace Maker	○	Yes	◉	No	Renal Dialysis	○	Yes	◉	No
Heart Trouble/Disease	○	Yes	◉	No	Rheumatic Fever	○	Yes	◉	No
Hemophilia	○	Yes	◉	No	Rheumatism	○	Yes	◉	No
Hepatitis A	○	Yes	◉	No	Scarlet Fever	○	Yes	◉	No
Hepatitis B or C	○	Yes	◉	No	Shingles	○	Yes	◉	No
Herpes	○	Yes	◉	No	Sickle Cell Disease	○	Yes	◉	No
High Blood Pressure	○	Yes	◉	No	Sinus Trouble	○	Yes	◉	No
Hives or Rash	○	Yes	◉	No	Spina Bifida	○	Yes	◉	No
Hypoglycemia	○	Yes	◉	No	Stomach/Intestinal Disease	○	Yes	◉	No
Irregular Heartbeat	○	Yes	◉	No	Stroke	○	Yes	◉	No
Kidney Problems	○	Yes	◉	No	Swelling of Limbs	○	Yes	◉	No
Leukemia	○	Yes	◉	No	Thyroid Disease	○	Yes	◉	No
Liver Disease	○	Yes	◉	No	Tonsillitis	○	Yes	◉	No
Low Blood Pressure	○	Yes	◉	No	Tuberculosis	○	Yes	◉	No
Lung Disease	○	Yes	◉	No	Tumors or Growths	○	Yes	◉	No
Mitral Valve Prolapse	○	Yes	◉	No	Ulcers	○	Yes	◉	No

Have you ever had a joint replacement? ○ Yes ◉ No If yes, date of surgery

Are you required to take pre-medication for this?

Have you ever had any 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 (patient's) health. It it my responsibility to inform the dental office of any changes in medical data.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

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