

Larry D Tidwell, DMD, PC

MEDICAL HISTORY

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?

Asprin 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

Alzheimer's Disease Yes No

Anaphylaxis Yes No

Anemia Yes No

Angina Yes No

Arthritis/ Gout Yes No

Artificial Heart Valve Yes No

Artificial Joint Yes No

Asthma Yes No

Blood Disease Yes No

Blood Transfusion Yes No

Breathing Problems Yes No

Bruise Easily Yes No

Cancer Yes No

Chemotherapy Yes No

Chest Pains Yes No

Cold Sores Yes No

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|----------------------------|----------------|
| Congenital Heart Disorder | ___ Yes ___ No |
| Convulsions | ___ Yes ___ No |
| Cortisone Medicine | ___ Yes ___ No |
| Diabetes | ___ Yes ___ No |
| Drug Addiction | ___ Yes ___ No |
| Easily Winded | ___ Yes ___ No |
| Emphysema | ___ Yes ___ No |
| Epilepsy or Seizures | ___ Yes ___ No |
| Excessive Bleeding | ___ Yes ___ No |
| Excessive Thirst | ___ Yes ___ No |
| Fainting Spells/Dizziness | ___ Yes ___ No |
| Frequent Cough | ___ Yes ___ No |
| Frequent Diarrhea | ___ Yes ___ No |
| Frequent Headaches | ___ Yes ___ No |
| Genital Herpes | ___ Yes ___ No |
| Glaucoma | ___ Yes ___ No |
| Hay Fever | ___ Yes ___ No |
| Heart Attack/Failure | ___ Yes ___ No |
| Heart Murmur | ___ Yes ___ No |
| Heart Pace Maker | ___ Yes ___ No |
| Heart Trouble/Disease | ___ Yes ___ No |
| Hemophilia | ___ Yes ___ No |
| Hepatitis A | ___ Yes ___ No |
| Hepatitis B or C | ___ Yes ___ No |
| Herpes | ___ Yes ___ No |
| High Blood Pressure | ___ Yes ___ No |
| Hives or Rashes | ___ Yes ___ No |
| Hypoglycemia | ___ Yes ___ No |
| Irregular Heartbeat | ___ Yes ___ No |
| Kidney Problems | ___ Yes ___ No |
| Leukemia | ___ Yes ___ No |
| Liver Disease | ___ Yes ___ No |
| Low Blood Pressure | ___ Yes ___ No |
| Lung Disease | ___ Yes ___ No |
| Mitral Valve Prolapse | ___ Yes ___ No |
| Pain in Jaw Joints | ___ Yes ___ No |
| Parathyroid Disease | ___ Yes ___ No |
| Psychiatric Care | ___ Yes ___ No |
| Radiation Treatments | ___ Yes ___ No |
| Recent Weight Loss | ___ Yes ___ No |
| Renal Dialysis | ___ Yes ___ No |
| Rheumatic Fever | ___ Yes ___ No |
| Rheumatism | ___ Yes ___ No |
| Scarlet Fever | ___ Yes ___ No |
| Shingles | ___ Yes ___ No |
| Sickle Cell Disease | ___ Yes ___ No |
| Sinus Trouble | ___ Yes ___ No |
| Spina Bifida | ___ Yes ___ No |
| Stomach/Intestinal Disease | ___ Yes ___ No |

Stroke Yes No
Swelling of Limbs Yes No
Thyroid Disease Yes No
Tonsillitis Yes No
Tuberculosis Yes No
Tumors or Growths Yes No
Ulcers Yes No
Venereal Disease Yes No
Yellow Jaundice Yes No

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 (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 _____