CHRISTY SAVAS, DDS

MEDICAL HISTORY

Patient Name: _____ **DOB:** _____

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.

Physician: _____ **Phone:**_____
Pharmacy: _____ **Phone:**_____

Are you under a physician's care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	O Yes O No	If yes, please list: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	_____
Are you on a special diet?	O Yes O No	_____
Do you use tobacco?	O Yes O No	
Do you use controlled substances?	O Yes O No	

Women are you:
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? O Yes O 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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient, Parent or Guardian: _____ **Date:** _____