Medical History --- Bret Davis DMD, PC

Patient Name: _____

Patient Birth Date: _____

Although dental personnel 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 medication, pills, or drugs?	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: _____

Women:	Are you -	Pregnant?	YES	NO
		Trying to get pregnant?	YES	NO
		Nursing?	YES	NO

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If "other", please explain: _____

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

AIDS/HIV Positive	Cold Sores/Fever	Frequent Headaches	Hypoglycemia	Rheumatism
Alzheimer's Disease	Blisters	Genital Herpes	Irregular Heartbeat	Scarlet Fever
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Kidney Problems	Shingles
Anemia	Convulsions	Hay Fever	Leukemia	Sickle Cell Disease
Angina	Cortisone Medicine	Heart Attack/Failure	Liver Disease	Sinus Trouble
Arthritis/Gout	Diabetes	Heart Murmur	Low Blood Pressure	Spina Bifida
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Lung Disease	Stomach/Intestinal Disease
Artificial Joint	Easily Winded	Heart Trouble/Disease	Mitral Valve Prolapse	Stroke
Asthma	Emphysema	Hemophilia	Pain in Jaw Joints	Swelling of Limbs
Blood Disease	Epilepsy or Seizures	Hepatitis A	Parathyroid Disease	Thyroid Disease
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Psychiatric Care	Tonsillitis
Breathing Problem	Excessive Thirst	Herpes	Radiation Treatments	Tuberculosis
Bruise Easily	Fainting	High Blood Pressure	Recent Weight Loss	Tumors or Growths
Cancer	Spells/Dizziness	Hives or Rash	Renal Dialysis	Ulcers
Chemotherapy	Frequent Cough		Rheumatic Fever	Venereal Disease
Chest Pains	Frequent Diarrhea			Yellow Jaundice

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: _____