

The Offices of Fredrick M. Vega, D.D.S., P.C. & Associates

MEDICAL HISTORY

Patient Name _____ Patient Date of Birth _____

Medical Physician's Name _____ Date of Last Physical _____

Medical Physician's Address & Phone # _____

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 medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions:

Are you under a physician's care now? ___No ___Yes

Have you ever been hospitalized or had a major operation? ___No ___Yes

Have you ever had a serious head or neck injury? ___No ___Yes

Are you taking any medications, pills, or drugs? ___No ___Yes If yes, please list _____

Are you ALLERGIC to any of the following? ___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics ___Other, please list _____ ___No Known Allergies

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

- ___AIDS/HIV Positive ___Cold Sores/Fever ___Frequent Headaches ___Kidney Problems ___Sickle Cell Disease
___Alzheimer's Disease ___Blisters ___Genital Herpes ___Leukemia ___Sinus Troubles
___Anaphylaxis ___Congenital Heart ___Glaucoma ___Liver Disease ___Spina Bifida
___Anemia ___Disorder ___Hay Fever ___Low Blood Pressure ___Stomach/Intestinal
___Angina ___Convulsions ___Heart Attack/Failure ___Lung Disease ___Disease
___Arthritis/Gout ___Cortisone Medicine ___Heart Murmur ___Mirtal Valve Prolapse ___Stroke
___Artificial Heart Valve ___Diabetes ___Heart Pace Maker ___Pain in Jaw Joints ___Swelling of Limbs
___Artificial Joint ___Drug Addiction ___Heart ___Parathyroid Disease ___Thyroid Disease
___Asthma ___Easily Winded ___Trouble/Disease ___Psychiatric Care ___Tonsillitis
___Blood Disease ___Emphysema ___Hemophilia ___Radiation Treatment ___Tuberculosis
___Blood Transfusion ___Epilepsy / Seizures ___Hepatitis A ___Recent Weight Loss ___Tumors / Growths
___Breathing Problems ___Excessive Bleeding ___Hepatitis B or C ___Renal Dislysis ___Ulcers
___Bruise Easily ___Excessive Thirst ___Herpes ___Rheumatic Fever ___Venereal Disease
___Cancers ___Fainting Spells / ___High Blood Pressure ___Rheumatism ___Yellow Jaundice
___Chemotherapy ___Dizziness ___Hives or Rash ___Scarlet Fever ___Other
___Chest Pains ___Frequent Cough ___Hypoglycemia ___Shingles
___Frequent Diarrhea ___Irregular Heartbeat

Have you ever had any serious illness not listed above that you think we should know about? ___No ___Yes If yes, please list _____

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 _____

FOR OFFICIAL USE ONLY:

REVIEWED BY _____ DATE _____

BLOOD PRESSURE _____ MEDICAL ALERTS _____