Last Name First Name MI

Date of Birth

Macon County Public Health

Adult Dental Services Medical History

Questions	☑Yes	☑No	If you check Yes, then explain or list
Are you under a physician's care now?			Doctors Name:
Have you had a major operation or hospitalized?			
Have you had a serious head or neck injury?			
Do you take prescribed medications? (**Provide list**)			
Do you or have you taken Phen-Fen or Redux?			
Have you ever taken Bisphosphonates?			
Are you on a special diet?			
Do you use tobacco (smoke or other)?			Type Tobacco: How Much?
Do you use controlled substances?			

Circle any Allergies:				Women: complete or circle applicable:	
Aspirin	Penicillin	Codeine	Local Anesthetics	Pregnant – due date:	High Risk Yes/No
Acrylic	Metals	Latex	Sulfa Drugs	OB-GYN:	Nursing Yes/No
List Others:				Birth Control Medication:	

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

Have you ever had any serious illness not listed above? Yes (or) No Comments:

Surgery	Date	Physician	Release for Dental Treatment Y/N

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/Legal Guardian Relationship (Self, Parent, Guardian) Date