DENTAL PATIENT MEDICAL HISTORY FORM

SOURCE: General Anesthesia Dentistry

Lakewood HEALTH SYSTEM

Patient name _____ Birth date _____

	Yes	No	
Are you currently under a physician's care?		☐	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	☐	☐	If yes, please explain: _____
Have you ever had a serious head or neck injury?		☐	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?		☐	If yes, when? _____
Do you use controlled substances?		☐	If yes, please list: _____
Do you need to pre-medicate?		☐	If yes, please explain: _____

Are you allergic to any of the following? ☐*Aspirin* ☐*Penicillin* ☐*Codeine* ☐*Acrylic* ☐*Metal* ☐*Latex*
☐*Local anesthetics* ☐*Other, please list* _____

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

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV positive			Cortisone medication			Hemophilia			Renal dialysis		
Alzheimer's			Diabetes			Hepatitis A			Rheumatic fever		
Anaphylaxis			Drug addiction			Hepatitis B or C			Rheumatism		
Anemia			Easily winded			Herpes			Scarlet fever		
Angina			Emphysema			High blood pressure			Shingles		
Epilepsy or seizures			Hives or rash			Sickle cell disease			Artificial heart valve	☐	
Excessive bleeding			Hypoglycemia			Sinus trouble			Artificial joint		
Excessive thirst			Irregular heartbeat			Spina bifida			Asthma		
Fainting spells/dizziness	☐		Kidney problems			Blood disease			Frequent cough		
Leukemia			Stroke			Blood transfusion			Frequent diarrhea		
Liver disease			Swelling limbs			Breathing problems			Frequent headaches	☐	
Low blood pressure			Thyroid disease			Lung disease			Cancer		
Glaucoma			Mitral valve prolapse			Tuberculosis			Chemotherapy		
Hay fever			Pain in jaw/joints			Tumors or growths			Chest pains		
Heart attack/failure			Parathyroid disease			Ulcers			Heart murmur		
Psychiatric care			Congenital heart disorder	☐		Heart pacemaker			Radiation treatment	☐	
Yellow jaundice			Convulsions			Heart trouble/disease	☐		Recent weight loss		

Have you ever had any serious illness not listed above?

☐ Yes If yes, please explain _____

☐ No

Please list all the patient's medical diagnoses _____

_____

Date of the patient's last cardiology visit _____ Location _____

Date of the patient's last neurology visit _____ Location _____

If patient is taking anti-seizure medication, date medication levels were last checked _____

Please state medical necessity of use of general anesthesia for completion of dental treatment _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing inaccurate information can be dangerous to me (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient or caregiver _____ Date _____