NOVAK FAMILY DENTISTRY

Dr. Shauna Novak • Dr. Debra McGill

MEDICAL HISTORY

PATIENT NAME: ____ Birth Date: ____________________

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 your 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 medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ____________________

Are you on a special diet? ☐ Yes ☐ No ____________________

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Do you need antibiotic pre-medication prior to dental treatment? ☐ Yes ☐ No

WOMEN: Are you...

☐ Pregnant / Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

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, any of the following?

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

Have you ever had any serious illness or surgery? ☐ Yes ☐ No If yes, please explain: ____________________

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Comments: ____

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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: ____________________