KREUZER FAMILY DENTISTRY

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Dental / Medical Health History

Current and past health problems and medications can affect the care we provide. Please answer as completely as you can.

Patient name _____ Date of birth _____ Today's date _____

GENERAL HEALTH

Check Yes or No for each. Add details below for anything marked Yes.

- Is the patient under a physician's care now? ☐ Yes ☐ No
- Has the patient ever been hospitalized or had a major operation? ☐ Yes ☐ No
- Has the patient had a serious head or neck injury? ☐ Yes ☐ No
- Is the patient taking medications, pills, or drugs? ☐ Yes ☐ No
- Does the patient take, or has the patient taken, Phen-Fen or Redux? ☐ Yes ☐ No
- Is the patient on a special diet? ☐ Yes ☐ No
- Does the patient use tobacco? ☐ Yes ☐ No
- Any previous hospitalizations, surgeries, or serious illnesses? ☐ Yes ☐ No
- Any serious illness or condition not listed on this form? ☐ Yes ☐ No

If the patient may become pregnant — is she: ☐ Pregnant or trying to conceive ☐ Nursing ☐ Taking oral contraceptives

Details for anything marked Yes _____

ALLERGIES

Check all that apply.

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics ☐ Other: _____

MEDICAL CONDITIONS

Check anything the patient has now or has had in the past.

- ☐ ADD / ADHD
- ☐ AIDS / HIV positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety disorder
- ☐ Arthritis / gout
- ☐ Artificial heart valve
- ☐ Artificial joint
- ☐ Asperger's
- ☐ Asthma
- ☐ Autism
- ☐ Blood disease
- ☐ Blood transfusion
- ☐ Breathing problems
- ☐ Bruises easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest pains
- ☐ Cold sores / fever blisters
- ☐ Congenital heart disorder
- ☐ Convulsions
- ☐ Cortisone medicine
- ☐ Diabetes — Type I
- ☐ Diabetes — Type II
- ☐ Down syndrome
- ☐ Drug addiction
- ☐ Easily winded
- ☐ Emphysema
- ☐ Epilepsy or seizures *
- ☐ Excessive bleeding
- ☐ Excessive thirst
- ☐ Fainting spells / dizziness
- ☐ Fetal alcohol syndrome
- ☐ Frequent cough
- ☐ Frequent diarrhea
- ☐ Frequent headaches
- ☐ Genital herpes
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart attack / failure
- ☐ Heart murmur *
- ☐ Heart pacemaker
- ☐ Heart trouble / disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hives or rash
- ☐ Hypoglycemia
- ☐ Irregular heartbeat
- ☐ Kidney problems
- ☐ Leukemia
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Mitral valve prolapse
- ☐ Pain in jaw joints
- ☐ Parathyroid disease
- ☐ Psychiatric care
- ☐ Radiation treatments
- ☐ Recent weight loss
- ☐ Renal dialysis
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Scarlet fever
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus trouble
- ☐ Special needs / developmental delay
- ☐ Spina bifida
- ☐ Stomach / intestinal disease
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Yellow jaundice

* If heart murmur — antibiotics needed first? ☐ Yes ☐ No _____

* If epilepsy or seizures — date of last seizure _____

ORAL HABITS

Check all that apply.

☐ Sucking thumb or finger ☐ Sucking or biting lip ☐ Chewing or biting nails ☐ Chewing hard objects ☐ Grinding teeth ☐ Clenching jaw

Anything else we should know? _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to the patient's health, and that it is my responsibility to inform the dental office of any changes in the patient's medical status. I also authorize the dental staff to perform the necessary dental services the patient may need.

This form has been reviewed with the patient, parent, or guardian, and the conditions noted above are accurate.

Signature of patient, parent, or guardian _____ Date _____ Signature of providing dentist _____ Date _____