

2755 N Wickham Rd, Suite 101  
Melbourne, FL 32935  
(321) 259-4666

## Medical History

Although we 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 medication you may be taking, could have an important interrelationship with the dentistry you will receive. We appreciate you answering the following questions as completely and accurately as possible. If you have any questions or are not sure how to answer one of the questions, please discuss the matter with one of our team. Thank you.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

- Are you currently under a physician's care?  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 ever 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

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 Anesthetic

Other If yes, please explain: \_\_\_\_\_

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

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain \_\_\_\_\_

Comments: \_\_\_\_\_