FOOTHILL
FAMILY DENTISTRY
J. Michael Carpenter, DMD, PLLC

MEDICAL HISTORY FOR: _____ : Date: ____/_____/_____

Although dental personnel primarily treat the area around your mouth, your mouth is part of your entire body. Health problems that you many have, or your medications, could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions regarding your overall health.

Are you under a medical provider's care now?	O Yes O No	If Yes who:
Have you ever been hospitalized or had a major operation?	O Yes O No	If Yes please explain:
Have you had a serious head or neck injury?	O Yes O No	If Yes please explain:
Are you taking any medications, pills, or drugs?	O Yes O No	If Yes please explain:
Do you take, or have you taken any bone medications for osteoporosis?	O Yes O No	If Yes please explain:
Are you on a special diet?	O Yes O No	If Yes please explain:
Do you use any controlled substances?	O Yes O No	If Yes please explain:

Women: Are you:

Pregnant or trying to conceive?	O Yes O No	O Taking oral contraceptives?

Are you allergic to any of the following?

O Aspirin	O Penicillin	O Codeine	O Acrylic
O Metal	O Latex	O Acrylic	O Local Anesthetics
Other? Please list:			

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

AIDS / HIV Positive	O Yes	O No	Chest Pains	O Yes	O No	Genital Herpes	O Yes	O No
Alzheimer's Disease	O Yes	O No	Congenital Heat Disorder	O Yes	O No	Glaucoma	O Yes	O No
Anaphylaxis	O Yes	O No	Convulsions	O Yes	O No	Hay Fever	O Yes	O No
Anemia	O Yes	O No	Yellow Jaundice	O Yes	O No	Heart Attack	O Yes	O No
Angina	O Yes	O No	Cortisone Medicine	O Yes	O No	Heart Murmur	O Yes	O No
Arthritis / Gout	O Yes	O No	Diabetes	O Yes	O No	Pacemaker	O Yes	O No
Artificial Heart Valve	O Yes	O No	Drug Addiction	O Yes	O No	Heart Trouble	O Yes	O No
Artificial Joint	O Yes	O No	Easily Winded	O Yes	O No	Hemophilia	O Yes	O No
Asthma	O Yes	O No	Emphysema	O Yes	O No	Hepatitis A	O Yes	O No
Blood Disease	O Yes	O No	Epilepsy or Seizures	O Yes	O No	Hepatitis B / C	O Yes	O No
Blood Transfusion	O Yes	O No	Excessive Bleeding	O Yes	O No	Herpes	O Yes	O No
Breathing Problems	O Yes	O No	Excessive Thrust	O Yes	O No	High Blood	O Yes	O No
Bruise Easily	O Yes	O No	Fainting or Dizziness	O Yes	O No	Pressure		
Cancer	O Yes	O No	Frequent Cough	O Yes	O No	High	O Yes	O No
Chemotherapy	O Yes	O No	Frequent Diarrhea	O Yes	O No	Cholesterol		

Hives or Rash	O Yes	O No	Pain in Jaw Joints	O Yes	O No	Sickle Cell Disease	O Yes	O No
Low blood sugar	O Yes	O No	Parathyroid Disease	O Yes	O No	Sinus Trouble	O Yes	O No
Irregular Heartbeat	O Yes	O No	Psychiatric Care	O Yes	O No	Spina Bifida	O Yes	O No
Kidney Problems	O Yes	O No	Radiation Treatments	O Yes	O No	Stomach Trouble	O Yes	O No
Leukemia	O Yes	O No	Recent Weight Loss	O Yes	O No	Stroke	O Yes	O No
Liver Disease	O Yes	O No	Renal Dialysis	O Yes	O No	Swelling of Limbs	O Yes	O No
Low Blood Pressure	O Yes	O No	Rheumatic Fever	O Yes	O No	Thyroid Disease	O Yes	O No
Lung Disease	O Yes	O No	Rheumatism	O Yes	O No	Tonsillitis	O Yes	O No
Mitral Valve Prolapse	O Yes	O No	Scarlet Fever	O Yes	O No	Tuberculosis	O Yes	O No
Osteoporosis	O Yes	O No	Shingles	O Yes	O No	Tumors	O Yes	O No
Ulcers	O Yes	O No	Venereal Disease	O Yes	O No			

Have you ever had any serious illness not listed above? O Yes O No / If Yes:_____

Comments:

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 my medical status.

Signature of Patient or Guardian: _____

Date: ____/____/_____