PERSONAL CARE DENTAL GROUP, LLC
9500 E. 63rd Street, Suite 103
Raytown, MO 64133
816.737.1110
www. personalcaredental.com

# MEDICAL HISTORY FORM

**Name: ______________________ Date of Birth:_____________**

**Although dental professionals 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 that you may be taking, could have a profound relationship with the dentistry you 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 If yes, please explain:____________________

Are you on a special diet? ☐ Yes ☐ No
If yes, please explain:____________________
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

**FOR WOMEN ONLY:**
Are you pregnant/ trying to get pregnant? ☐Yes ☐No
Taking oral contraceptives ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

**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?**

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/ Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breahing Problems
- ☐ Bruise Easily
- ☐ Cancer/ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/ Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ 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
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors/ Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:____________________

***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 my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Patient Signature:** ____________________ **Date:**____________________

**DOCTOR'S COMMENTS:**____________________

**Doctor's Signature:** ____________________ **Date:** ____________________