Macon County Public Health

Health & Medical History

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all of the following questions.

Questions	☑Yes	☑No	If you check Yes, then explain or list
Are you under a physician's care now?			Doctors Name:
Have you had a major operation or hospitalized?			
Have you had a serious head or neck injury?			
Do you take prescribed medications?			********** If YES, list On Next Page **********
Do you or have you taken Phen-Fen or Redux?			
Are you on a special diet?			
Do you use tobacco (smoke or other)?			Type Tobacco: How Much?
Do you use controlled substances?			********** If YES, list On Next Page **********

Circle any Allergies:	Women: complete or circle applicable:
Aspirin Penicillin Codeine	Pregnant – due date: High-Risk: yes (or) no
Latex Metals Local Anesthetics Acrylic	OB-GYN: Nursing
List Others:	Trying to get Pregnant ***List BC Medication on next page**

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

List Any Other Condition(s) or Disease(s) not listed above:

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 at each and every dental visit. Minimally, updated health form must be completed yearly

SIGN _____ _____ _____

Signature of Patient/Parent/Legal Guardian | Relationship (Self, Parent, Guardian) | Date

Macon County Public Health

Patient's Medication, Allergies, Vitamins, Surgery Form

Medications/Vitamins	Dosage	Intervals Taken	Reason for Medication
List Any Bisphosphonates taken (such as Boniva, Fosamax, Zometa, Actonel)		**Start Date**	**Discontinue Date**

Allergies (check all that apply):	
☐ **Aspirin** Reaction:	☐ **Latex** Reaction:
☐ **Penicillin** Reaction:	☐ **Metals** Reaction:
☐ **Codeine** Reaction:	☐ **Acrylic** Reaction:
☐ **Local Anesthetics** Reaction:	☐ **Others** (list): Reaction(s):

Surgery	Date	Physician	Released for Dental Treatment enter: Y (or) N

To the best of my knowledge, this information is accurate and complete.

SIGN

_____ _____

Print Patient's Name — Signature of Patient/Parent/Legal Guardian

_____ _____

Relationship (Self, Parent, Guardian) — Date