MEDICAL HISTORY

We would like to *THANK YOU* for choosing the Nova Dental Center for your ultimate dental health and treatment. Please answer the following questions as the health issues you may have and/or the medications you are taking could have an important interrelationship with the care you receive.

Are you under a physician's care now? ◯ Yes ◯ No If *YES*, please explain: _____

Have you u ever been hospitalized or had a major operation? ◯ Yes ◯ No If *YES*, please explain: _____

Have you 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 _____

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? ◯ Yes ◯ No Taking *ORAL CONTACEPTIVES*? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following? ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Latex ◯ Local Anesthetics

◯ Other: _____

Do you have or have you had any of the following *(CHECK ALL THAT APPLY)*:

AIDS/HIV+ ◯	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 Disease ◯
Artificial Heart Valve ◯	Excessive Bleeding ◯	Hypoglycemia ◯	Sinus Trouble ◯
Artificial Joint ◯	Excessive Thirst ◯	Irregular Heartbeat ◯	Spina Bifida ◯
Asthma ◯	Fainting Spell/Dizziness ◯	Kidney Problems ◯	Stomach/Intestinal Disease ◯
Blood Disease ◯	Frequent Cough ◯	Leukemia ◯	Stroke ◯
Blood Transfusion ◯	Frequent Diarrhea ◯	Liver Disease ◯	Swelling of Limbs ◯
Breathing Problem ◯	Frequent Headaches ◯	Low Blood Pressure ◯	Thyroid Disease ◯
Bruise Easily ◯	Genital Herpes ◯	Lung Disease ◯	Tonsillitis ◯
Cancer ◯	Glaucoma ◯	Mitral Valve Prolapse ◯	Tuberculosis ◯
Chemotherapy ◯	Hay Fever ◯	Pain in Jaw Joints ◯	Tumors or Growths ◯
Chest Pains ◯	Heart Attack/Failure ◯	Parathryoid Disease ◯	Ulcers ◯
Cold Sores/Fever Blisters ◯	Heart Murmur ◯	Psychiatric Care ◯	Venereal Disease ◯
Congenital Heart Disorder ◯	Heart Pace Maker ◯	Radiation Treatments ◯	Yellow Jaundice ◯
Convulsions ◯	Heart Trouble/Disease ◯	Recent Weight Loss ◯	

Have you ever had any serious illness not listed above? Yes No If *YES*, please explain: _____

To be best of my knowledge, the questions on this form have been accurately answered. I understand by providing incorrect information can be dangerous to my (or the Patient's) health. It is my responsibility to inform the Nova Dental Center Team of any changes in medical health.

Signature of Patient, Parent or Guardian: _____ **Date:** _____