

# Jason T. Lipscomb D.D.S.

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

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 receive. Thank you for answering the following questions.

Are you under a physician's care <b>now</b> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Have you <b>ever</b> had a serious head or neck injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Are you taking any medications, pills, or drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____ (amount & dosage)
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Are you on a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____

If yes, please explain

Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Women: Are you:	<input type="checkbox"/> Pregnant/Trying to get pregnant	<input type="checkbox"/> Nursing	<input type="checkbox"/> Taking Oral Contraceptives					
Do you use controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Are you allergic to any of the following?	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Other
If Other, please explain: _____												

### Check if you have, or have had, any of the following:

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

Have you taken corticosteroids (cortisone, steroids) in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Have you ever had any serious illness not listed above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Comments/Additional Medications:	_____			

If yes, please explain

\*Condition may require medication    N/A – Not answered by patient

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 changed in medical status.

Signature of Patient, Parent, or Guardian

Date