William J. Bennett III, D.D.S & Associates

Print Name: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship 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:

_____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Local Anesthetics

Please list any other allergies not listed above:

_____

Women:

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking oral Contraceptives? ☐ Yes ☐ No

MEDICAL HISTORY CONTINUED

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 Transfusion
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Drug Addiction
☐ Diabetes
☐ Epilepsy or Seizures
☐ Fainting Spells/Dizziness
☐ Excessive Thirst
☐ Frequent Cough
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Psychiatric Care
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid/Parathyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain:

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held to the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature Date

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