Wolff Family Dentistry, LLP
Medical History **Patient Name: _____**

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 the following questions.

Are you undergoing any treatment(s) now?	No	Yes: _____
In the last five years, have you been hospitalized?	No	Yes: _____
Have you ever had a serious head or neck injury?	No	Yes: _____
Do you take, or have you taken Phen-Fen or Redux?	No	Yes: _____
Are you on a special diet?	No	Yes: _____
Do you use tobacco?	No	Yes: _____
Do you use controlled substances?	No	Yes: _____
Are you taking any medications?	No	Yes

Please list all your medications:

_____

_____

Please circle any of the following you are allergic to:

Aspirin Penicillin Codeine Acrylic Latex Local Anesthetics Other:_____

Do you have, or have you had any of the following? Please circle:

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

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.

Signature of Patient (Parent, or Guardian) _____ Date: _____