MEDICAL HISTORY

PATIENT NAME: _____ Birth Date: _____

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 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 list all medications you are currently taking:

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ 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 contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes to any, please explain: _____

Do you have, or have you had, any of the following?

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

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

Comments: _____

_____

_____

_____

Emergency Contact Name: _____ Phone: _____

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 _____