

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 explain: _____
- 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 Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

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

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

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

Comments: _____

To the best of my knowledge, the questions on this form 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 _____