Medical History

Date:_____

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.

Please list your primary physician(s). _____

Are you under a physician's care now? ☐ Yes ☐ No

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes _____

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

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

If yes _____

Are you on a special diet? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No

Do you or have you ever used tobacco? ☐ Yes ☐ No Do you snore, or have you been told you snore? ☐ 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 ☐ Latex ☐ Local Anesthetics

☐ Erythromycin ☐ Tetracycline ☐ Fluoride ☐ Metals (Gold, Stainless steel) ☐ Other Please explain:_____

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

AIDS/HIV Positive	☐ Yes ☐ No	Excessive thirst	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Osteoporosis/osteopenia	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Frequent cough	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent headaches	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Radiation treatments	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Artificial joint	☐ Yes ☐ No	Hay fever	☐ Yes ☐ No	Renal dialysis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Attack/failure	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Heart pacemaker	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Breathing problems	☐ Yes ☐ No	Heart trouble/Disease	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis (Type_____)	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No	High Blood pressure	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Cold sores/Fever blisters	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No	Stomach/intestinal disease	☐ Yes ☐ No
Congenital heart disorder	☐ Yes ☐ No	Hives, rash, hay fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	HPV(Human Papilioma Virus)	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cortisone medication	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tumor, abnormal growth	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Epilepsy/convulsions or seizures	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Excessive Bleeding	☐ Yes ☐ No	Lung disease	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes _____

Have you been diagnosed with cancer? ☐ Yes ☐ No If yes _____

Comments:

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 or Parent/Guardian _____ Date _____

Signature of Dr. _____ Date _____