MEDICAL HISTORY

Patient Name: _____ **Birth Date:** _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your 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 read carefully and answer <u>each</u> question below*****

Are you under a physician's care now?	☐ No	☐ Yes	If yes: _____
Have you ever been hospitalized or had a major operation?	☐ No	☐ Yes	If yes: _____
Have you ever had a serious head or neck injury?	☐ No	☐ Yes	If yes: _____
Are you taking any medications, pills, or drugs?	☐ No	☐ Yes	If yes: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ No	☐ Yes	If yes: _____
Have you ever taken Fosamax, Bonivia, Actonel or any other medication containing bisphosphonates?	☐ No	☐ Yes	If yes: _____
Are you on a special diet?	☐ No	☐ Yes	
Do you use tobacco?	☐ No	☐ Yes	
Do you use controlled substances?	☐ No	☐ Yes	If yes: _____

<u>Women</u>: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you <u>allergic</u> to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? Explain: _____

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

AIDS/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
									Yellow Jaundice	☐ Yes	☐ No

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

If yes: _____

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 my medical status.

_____ _____

Signature of Patient, Parent or Guardian **Date**