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 you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions.

Are you under a physician's care now? ☐ yes ☐ no ____

Have you ever been hospitalized or had a major operation? ☐ yes ☐ no ____

Have you ever had a serious head or neck injury? ☐ yes ☐ no____

Are you taking any medications, pills, or drugs? ☐ yes ☐ no ____

Are you on a special diet? ☐ yes ☐ no____

Do you use tobacco? ☐ yes ☐ no

Do you use controlled substances? ☐ yes ☐ no

Have you ever taken any biosphosphonate drugs including:
Pamidronate (**ADP, Aredia**) ☐ yes ☐ no
Neridronate, Olpadronate, Alendronate (**Fosamax**) ☐ yes ☐ no
Ibandronate (**Boniva**) ☐ yes ☐ no
Risedronate (**Actonel**) ☐ yes ☐ no
Zoledronate (**Zometa**) ☐ yes ☐ no

Are you allergic to any of the following?

☐ Aspirin
☐Penicillin
☐Codeine
☐Acrylic
☐Metal
☐Latex
☐Local Anesthetics
☐Other, please list____

WOMEN:

Pregnant/Trying to get pregnant? ☐ yes ☐ no
Taking oral contraceptives? ☐ yes ☐ no
Nursing? ☐ yes ☐ no

Do you, or have you had, any of the following? Please circle those that apply.

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

Anything else we should be aware of? Comments?

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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___________