

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 bisphosphonate 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

Please list any medications:

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

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

Anything else we should be aware of? 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, PARENT, OR GUARDIAN _____ Date _____