Patient Medical History

Name_____ Date of Birth_____

Mailing Address_____

City:_____ State:_____ Zip:_____

Phone # we should have to contact you _____

E-mail address: _____

Emergency Contact _____

Emergency Phone_____

Health Problems that you may have or medications that you may be taking, may have an important interrelation with dental treatment. ***Thank you for answering these important questions about your health.***

Are you under a physician's care? ___ **Yes** ___ **No** If yes, please give MD's name & phone # _____

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 medication, pills or drugs (prescription or over-the-counter)___ **Yes** ___ **No** If yes, please list them

_____

Do you take, or have you taken Fosamax, Boniva, Actonel, Phen-Fen or Redux? ___ **Yes** ___ **No**

If yes, please list medication & if currently taking it, if not how long did you take it? _____

Are you on a special diet? ___ **Yes** ___ **No**

Have you ever used tobacco?___ **Yes** ___ **No**

Do you use controlled substances?___ **Yes** ___ **No**

Do you require PRE-MEDICATION? ___ **Yes** ___ **No**

Re: Children

Is your child up to date on his/her immunizations? _____

Does your child have any of the following habits:

___ grinding ____ thumb sucking ____bottle/sippy cup

Are you **allergic** to:

___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic

___ Metal ___ Latex ___ Local Anesthetics

Other?_____

(please list)

Women: Are you

____Pregnant/Trying to get pregnant? ____Nursing?

____Taking oral contraceptives?

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

- □ AIDS/HIV positive
- □ Alzheimer's Disease/
- □ Anaphylaxis
- □ Anemia
- □ Angina
- □ Arthritis/Gout
- □ Artificial Heart Valve
- □ Artificial Joint
- □ Asperger's / Autism
- □ Asthma
- □ Blood Disease
- □ Blood Transfusion
- □ Breathing Problem
- □ Bruise Easily
- □ Cancer
- □ Chemotherapy
- □ Chest Pains
- □ Cold Sores/Herpes
- □ Congenital Heart Disorder
- □ Convulsions
- □ Cortisone Medicine
- □ Dementia
- □ Diabetes
- □ Drug Addiction
- □ Easily Winded
- □ Emphysema
- □ Epilepsy or Seizures
- □ Excessive Bleeding
- □ Excessive Thirst
- □ Fainting Spells/ Dizziness
- □ Frequent Cough
- □ Frequent Diarrhea
- □ Frequent Headaches
- □ Glaucoma
- □ Hay Fever
- □ Heart Attack/Failure
- □ Heart Murmur
- □ Heart Pace Maker
- □ Heart Trouble/Disease
- □ Hemophilia
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ High Blood Pressure
- □ Hives or Rash
- □ Hypoglycemia
- □ Irregular Heartbeat
- □ Kidney Problems
- □ Leukemia
- □ Liver Disease
- □ Low Blood Pressure
- □ Lung Disease
- □ Mitral Valve Prolapse
- □ Multiple Sclerosis
- □ MRSA infection
- □ Pain in Jaw Joints
- □ Parathyroid Disease
- □ Parkinson's Disease
- □ Psychiatric Care
- □ Radiation Treatments
- □ 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
- □ Tonsilitis
- □ Tuberculosis
- □ Tumors or Growths
- □ Ulcers
- □ Venereal Disease
- □ Yellow Jaundice

Have you ever had any serious illness not listed above? **Yes** ____ **No** ____ (If yes, please explain)_____

_____

What would you like us to know about your dental concerns/experiences?

_____

_____

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 health or that of the patient. It is my responsibility to keep the dental office informed of medical status and update changes when they occur.

Signature of Patient, Parent or Guardian_____ Date_____