

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

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 medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

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

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? 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 Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

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

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

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

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 _____