Time 9:43 AM | Benson Family Dental Care | Date 4/22/2019

Medical History

Patient Name: | Birth Date: | Date Created:

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	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head, neck or back injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Do you brush your teeth? How often?	Yes No	If yes	
Do you floss or use a Water Pik? How often?	Yes No	If yes	
Do you use tobacco? Smoke? Chew? Vape? How often?	Yes No	If yes	
Do you or have you ever had an eating disorder? Which one?	Yes No	If yes	

Mark all of the following that apply to you...

Do you have dental anxiety ?	Yes No	Do you grind or clench your teeth?	Yes No
Do you have jaw pain?	Yes No	Do you chew on ice?	Yes No
Do you bite or chew your nails?	Yes No	Do you drink soda/sugar beverages?	Yes No
Do you wear a removable denture/partial?	Yes No	Do you wear a night guard?	Yes No

Women: Are you...

Pregnant?	Yes No	Nursing?	Yes No	Taking Oral Contraceptives?	Yes No

Are you allergic to any of the following?

Aspirin	Acrylic	Codeine	Latex
Metal	Penicillin	Sulfa Drugs	

Any other allergies not listed?	Yes No	If yes	
Have you ever had any adverse reactions to Local Anesthetic?	Yes No	If yes	

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

Acid Reflux/GERD	AIDS/HIV Positive	Alzheimer's Disease	Anaphylaxis
Angina	Artificial Heart Valve	Artificial Joint	Asthma
Blood Disease	Breathing Problems	Cancer	Canker Sores
Chemotherapy	Cold Sores/Fever Blisters	Congenital Heart Disease	Convulsions
Diabetes	Drug Addiction	Emphysema	Epilepsy or Seizures
Excessive Bleeding	Fainting Spells/Dizziness	Heart Attack/Failure	Heart Murmur
Heart Pacemaker	Heart Trouble/Disease	Hemoplilia	Hepatitis A
Hepatitis B or C	Herpes	High Blood Pressure	Hypoglycemia
Leukemia	Low Blood Pressure	Lung Disease/COPD	Mitral Valve Prolapse
Osteoporosis	Psychiatric Care	Radiation Treatments	Rheumatic Fever
Sinus Trouble	Stroke	Tuberculosis	Tumors or Growths

Have you had any other serious illness not listed above?	Yes No	If yes	

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:

X Date:_____