MEDICAL HISTORY

PATIENT NAME: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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?	Y	N	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Y	N	If yes, please explain: _____
Have you ever had a head or neck injury?	Y	N	If yes, please explain: _____
Do you take, or have you ever taken, Phen-Fen or Redux?	Y	N	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Y	N	
Do you use tobacco?	Y	N	
Are you on a special diet?	Y	N	
Do you use controlled substances?	Y	N	

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 you do, please explain: _____

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

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

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

Medications: _____

_____

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_____