MEDICAL HISTORY

NAME ______________________________ BIRTH DATE _______________ TODAY'S 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

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 medications, pills, or drugs? ___ Yes ___ No Please list: ______________________________

____

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? (Cigarettes, Chew, Vape Pen) ___ Yes ___ No If yes, how often? __________________

Women: Are you pregnant/trying to get pregnant? ___ Yes ___ No

Are you taking contraceptives? ___ Yes ___ No

Are you nursing? ___ Yes ___ No

Are you allergic to any of the following?

___ Aspirin ___ Penicillin ___ Codeine ___ Latex ___ Local Anesthetics ___ Acrylic ___ Metal ___ Sulfa drugs

___ Other If yes, please explain: ____

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

___ AIDS/HIV Positive ___ Cortisone Medicine ___ Hemophilia ___ Radiation Treatments

___ Alzheimer's Disease
___ Anaphylaxis
___ Anemia
___ Angina
___ Arthritis/Gout
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Breathing Problem
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Chest Pains
___ Cold sores/Fever blisters
___ Congenital Heart disorder
___ Convulsions

___ Diabetes
___ Drug Addiction
___ Easily Winded
___ Emphysema
___ Epilepsy or Seizures
___ Excessive Bleeding
___ Excessive Thirst
___ Fainting spells/Dizziness
___ Frequent Cough
___ Frequent Diarrhea
___ Frequent Headaches
___ Genital Herpes
___ Glaucoma
___ Hay Fever
___ Heart Attack/Failure
___ Heart Murmur
___ Heart Pacemaker
___ Heart Trouble/Disease

___ Hepatitis A
___ Hepatitis B or C.
___ Herpes
___ High Blood Pressure
___ High Cholesterol
___ Hives or Rash
___ Hypoglycemia
___Irregular Heartbeat
___ Kidney Problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse
___ Osteoporosis
___ Pain in jaw joints
___ Parathyroid Disease
___ Psychiatric Care

___ Recent Weight Loss
___ Renal Dialysis
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Trouble
___ Spina Bifida
___ Stomach/Intestinal Disease
___ Stroke
___ Swelling of arms or legs
___ Thyroid Disease
___ Tonsillitis
___ Tuberculosis
___ Tumors or growths
___ Ulcers
___ Yellow Jaundice

Have you ever had any serious illness not listed above? ___ Yes ___ No If yes, please list:

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.

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SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE _______________