

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please explain: _____
Are you taking any medications, pills, or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please list all medications you are currently taking _____
Do you take, or have you taken, Phep-Fep or Redux?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Do you use controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other

If yes to any, please explain: _____

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

<input type="checkbox"/> AIDS/HIV Positive <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Artificial Joint <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Breathing Problem <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chest Pains <input type="checkbox"/> Cold Sores/ Fever Blisters <input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Convulsions <input type="checkbox"/> Cortisone Medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Easily Winded <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy and Seizures <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Fainting <input type="checkbox"/> Spells/Dizziness <input type="checkbox"/> Frequent Cough <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Heart Attack/Failure <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Pace Maker <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hives or Rash <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pain in Jaw Joints <input type="checkbox"/> Parathyroid Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatments <input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shingles <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Spinal Bifida <input type="checkbox"/> Stomach/Intestinal Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Limbs <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tons <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors or Growths <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Yellow Jaundice
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Comments: _____

Emergency Contact Name: _____ Phone: _____

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: _____