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 taken, Phen-Fen or Redux?	□ Yes	□ No	If yes, please explain_____
Have you ever taken Fosamax, Boniva, Actonel or any 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 □ Acrylic □ Metal □ Latex □ Local Anesthetics
□ Other If yes, please explain_____

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

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

Have you ever had any serious illness not listed above? □ Yes □ No If yes, please explain_____

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_____