

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
Have you ever been hospitalized or had a major operation? Yes No
Have you ever had a serious head or neck injury? Yes No
Are you taking any medications, pills, or drugs? Yes No
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? 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 Local Anesthetics Acrylic Metal Latex Sulfa drugs
Other If yes, please explain:

Do you have, or have you had, any of the following?
AIDS/HIV Positive Yes No
Alzheimer's Disease Yes No
Anaphylaxis Yes No
Anemia Yes No
Angina Yes No
Arthritis/Gout Yes No
Artificial Heart Valve Yes No
Artificial Joint Yes No
Asthma Yes No
Blood Disease Yes No
Blood Transfusion Yes No
Breathing Problem Yes No
Bruise Easily Yes No
Cancer Yes No
Chemotherapy Yes No
Chest Pains Yes No
Cold Sores/Fever Blisters Yes No
Congenital Heart Disorder Yes No
Convulsions Yes No
Cortisone Medicine Yes No
Diabetes Yes No
Drug Addiction Yes No
Easily Winded Yes No
Emphysema Yes No
Epilepsy or Seizures Yes No
Excessive Bleeding Yes No
Excessive Thirst Yes No
Fainting Spells/Dizziness Yes No
Frequent Cough Yes No
Frequent Diarrhea Yes No
Frequent Headaches Yes No
Genital Herpes Yes No
Glaucoma Yes No
Hay Fever Yes No
Heart Attack/Failure Yes No
Heart Murmur Yes No
Heart Pacemaker Yes No
Heart Trouble/Disease Yes No
Hemophilia Yes No
Hepatitis A Yes No
Hepatitis B or C Yes No
Herpes Yes No
High Blood Pressure Yes No
High Cholesterol Yes No
Hives or Rash Yes No
Hypoglycemia Yes No
Irregular Heartbeat Yes No
Kidney Problems Yes No
Leukemia Yes No
Liver Disease Yes No
Low Blood Pressure Yes No
Lung Disease Yes No
Mitral Valve Prolapse Yes No
Osteoporosis Yes No
Pain in Jaw Joints Yes No
Parathyroid Disease Yes No
Psychiatric Care Yes No
Radiation Treatments Yes No
Recent Weight Loss Yes No
Renal Dialysis Yes No
Rheumatic Fever Yes No
Rheumatism Yes No
Scarlet Fever Yes No
Shingles Yes No
Sickle Cell Disease Yes No
Sinus Trouble Yes No
Spina Bifida Yes No
Stomach/Intestinal Disease Yes No
Stroke Yes No
Swelling of Limbs Yes No
Thyroid Disease Yes No
Tonsillitis Yes No
Tuberculosis Yes No
Tumors or Growths Yes No
Ulcers Yes No
Venereal Disease Yes No
Yellow Jaundice Yes No

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

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 _____