

## Medical History

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

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 and for providing information to help us better care for you as our patient.

Are you under a physician's care now?	Yes   No	If yes _____
Have you ever been hospitalized or had a major operation?	Yes   No	If yes _____
Have you ever had a serious head or neck injury?	Yes   No	If yes _____
Are you taking any medications, pills or drugs?	Yes   No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes   No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes   No	If yes _____
Are you on a special diet?	Yes   No	
Do you use tobacco?	Yes   No	
Do you use controlled substances?	Yes   No	If yes _____

Women, are you:  Pregnant / Trying to become pregnant?  Nursing?  Taking oral contraceptives?

### Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics	
<input type="checkbox"/> Metal (please specify) _____	<input type="checkbox"/> Other (please specify) _____		

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

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

Have you ever had any serious illness not listed? Yes | No If yes \_\_\_\_\_

Additional 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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient / Responsible party signature \_\_\_\_\_ Today's date \_\_\_\_\_