Medical History

Patient Name: _____

Birth Date: _____ Date Created:_____

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 physicians 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 get pregnant? ___ Nursing? ___ Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Yes ___No___ Penicillin Yes ___No___ Codeine Yes ___No___
Acrylic Yes ___No___ Metal Yes ___No___ Latex Yes ___No___
Sulfa Drugs Yes ___No___ Local Anesthetics Yes ___ No___

Other? Yes ___No___ If Yes to any, _____

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

Yes ___No___ AIDS/HIV positive
Yes ___No___ Alzheimer's Disease
Yes ___No___ Anaphylaxis
Yes ___No___ Anemia
Yes ___No___ Angina
Yes ___No___ Arthritis/Gout
Yes ___No___ Artificial HeartValve
Yes ___No___ Artificial Joint
Yes ___No___ Asthma
Yes ___No___ Blood Disease
Yes ___No___ Blood Transfusion
Yes ___No___ Breathing Problems
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 Diseases
Yes ___No___ Stroke
Yes ___No___ Swelling of Limbs
Yes ___No___ Thyroid Disease
Yes ___No___ Tonsillitis
Yes ___No___ Tuberculosis
Yes ___No___ Tumors or Growth
Yes ___No___ Ulcers
Yes ___No___ Venereal Disease
Yes ___No___ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes ___No ___ If yes _____

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:

X _____ Date: _____