Medical History

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 medications 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 _____

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 an 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 If Yes _____

Do you use tobacco? ❑ 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 ❑ Penicillin ❑ Codeine ❑ Acrylic

❑Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics

Other: _____

Do you use controlled substances? ❑ Yes ❑ No If Yes

_____

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

AIDS/HIV Positive	❑ Yes ❑ No	Chest Pains	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No
Alzheimer's Disease	❑ Yes ❑ No	Cold Sores/Fever Blisters	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Congenital Heart Disorder	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Convulsions	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Cortisone Medicine	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Drug addiction	❑ Yes ❑ No	Heart Trouble/Disease	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Easily Winded	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No	Hepatitis B or C	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Excessive Bleeding	❑ Yes ❑ No	Herpes	❑ Yes ❑ No
Breathing Problems	❑ Yes ❑ No	Excessive Thirst	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Fainting Spells/Dizziness	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Frequent Cough	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No		

Do you have, or have you had, any of the following? Cont…..

Hypoglycemia	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Stomach/Intestinal Disease	❑ Yes ❑ No
Irregular Heartbeat	❑ Yes ❑ No	Radiation Treatments	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Kidney Problems	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Leukemia	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Liver Disease	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Low Blood Pressure	❑ Yes ❑ No	Rheumatism	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Lung Disease	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Mitral Valve Prolapse	❑ Yes ❑ No	Shingles	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Osteoporosis	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Pain in Jaw Joints	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Parathyroid Disease	❑ Yes ❑ No	Spina Bifida	❑ Yes ❑ No		

Have you ever had any serious illness not listed? ❑ 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: _____