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.

WOMEN: Are you

Pregnant/ Trying to get pregnant? Y◯ N◯ Taking oral contraceptives? Y◯ N◯ Nursing? Y◯ N◯

ALLERGIES: Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acryllic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other_____

Are you under a physician's care now?	Y◯ N◯	*If yes, explain*_____
Have you ever been hospitalized or had a major operation?	Y◯ N◯	*If yes, explain*_____
Have you had a serious head or neck injury?	Y◯ N◯	*If yes, explain*_____
Are you taking any medications, pills or drugs?	Y◯ N◯	*If yes, explain*_____
Do you take, or have you taken, Phen-Fen or Redux?	Y◯ N◯	*If yes, explain*_____
Are you on a special diet?	Y◯ N◯	*If yes, explain*_____
Do you use tobacco?	Y◯ N◯	*If yes, explain*_____
Do you use controlled substances?	Y◯ N◯	*If yes, explain*_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphonates?	Y◯ N◯	*If yes, explain*_____

Do you have, or have you had, any of the following? *(Check for yes.)*

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

Have you ever had any serious illness not listed above?_____

If yes, please explain _____

Medications:_____

_____

What are your goals/concerns with your teeth? _____

_____

When was your last cleaning? _____

Are you in any pain today? _____

To the best of my knowledge, the questions on this form have been answered accurately. I understanding 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**_____