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 If yes, please explain:					
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:					
Have you ever had a serious head or neck injury? 🚫 Yes 🚫 No 🛛 If yes, please explain:					
Are you taking any medications, pills, or drugs? () Yes () No If yes, please explain:					
Do you take, or have you taken, Phen-Fen or Redux? 🔘 Yes 🔘 No					
Have you ever taken Fosamax. Boniva, Actonel or any and a second					
other medications containing bisphosphonates? Ves Vo					
Are you	ı on a special diet? 🔘 Yes (🔿 No			
Do	you use tobacco? 🔘 Yes (🔿 No			
Do you use controlled substances? \bigcirc Yes \bigcirc 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		nesthetics	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	0	es () No Hemophilia es () No Hepatitis A	○ Yes ○ No ○ Yes ○ No	Radiation Treatments Recent Weight Loss	○ Yes ○ No ○ Yes ○ No
Anaphylaxis () Yes () No	š	es () No Hepatitis B o	ğ ğ	Renal Dialysis	
Anemia	9	es () No Herpes		Rheumatic Fever	
Angina O Yes O No	·	es 🔿 No 🛛 High Blood F	ğ ğ	Rheumatism	◯ Yes ◯ No
Arthritis/Gout O Yes O No	ļ,	es 🔿 No 🛛 High Cholest	ž ž	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve O Yes O No		es 🔿 No 🛛 Hives or Ras	h 🔿 Yes 🔿 No	Shingles	◯ Yes ◯ No
Artificial Joint O Yes O No	Excessive Thirst O Ye	es 🔿 No 🛛 Hypoglycemi	a 🔿 Yes 🔿 No	Sickle Cell Disease	◯ Yes ◯ No
Asthma O Yes O No	Fainting Spells/Dizziness O Ye	es 🔿 No 🛛 Irregular Hea	rtbeat 🔿 Yes 🔿 No	Sinus Trouble	◯ Yes ◯ No
Blood Disease O Yes O No		es 🔘 No 🛛 Kidney Probl	ems 🔿 Yes 🔿 No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion O Yes O No	Frequent Diarrhea OY	es 🔘 No 🛛 Leukemia	🔿 Yes 🔿 No	Stomach/Intestinal Diseas	e 🔿 Yes 🔿 No
Breathing Problem O Yes No	Frequent Headaches O Ye	es 🔿 No 🛛 Liver Diseas	e 🔿 Yes 🔿 No	Stroke	🔿 Yes 🔿 No
Bruise Easily O Yes O No	Genital Herpes	es 🔿 No 🛛 Low Blood P	ressure 🔿 Yes 🔿 No	Swelling of Limbs	🔿 Yes 🔿 No
Cancer O Yes O No		es 🚫 No 🛛 Lung Diseas	ă ă	Thyroid Disease	🔿 Yes 🔿 No
Chemotherapy O Yes O No	Hay Fever O Ye	es 🔘 No 🛛 Mitral Valve I	ă ă	Tonsillitis	◯ Yes ◯ No
Chest Pains Yes No		es 🔿 No 🛛 Osteoporosis	S Yes 🔿 No	Tuberculosis	
Cold Sores/Fever Blisters 🔿 Yes 🔿 No	Heart Murmur 🔿 Ye	es 🔘 No 🔋 Pain in Jaw 、	loints 🔿 Yes 🔿 No	Tumors or Growths	
Congenital Heart Disorder O Yes O No		es 🔘 No 🛛 Parathyroid [Disease 🔿 Yes 🔿 No	Ulcers	
Convulsions O Yes O No	Heart Trouble/Disease O Ye	es 🔘 No 📔 Psychiatric C	ã ã	Venereal Disease Yellow Jaundice	() Yes () No () 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.