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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

AIDS/HIV	☐	Cortisone Medicine	☐	Hemophilia	☐	Radiation Treatments	☐
Alzheimer's Disease	☐	Diabetes	☐	Hepatitis A	☐	Recent Weight Loss	☐
Anaphylaxis	☐	Drug Addiction	☐	Hepatitis B or C	☐	Renal Dialysis	☐
Anemia	☐	Easily Winded	☐	Herpes	☐	Rheumatic Fever	☐
Angina	☐	Emphysema	☐	High Blood Pressure	☐	Rheumatism	☐
Arthritis	☐	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/Intestinal 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 Prolepses	☐	Tonsillitis	☐
Chest Pains	☐	Heart Attack/Failure	☐	Osteoporosis	☐	Tumors or Growths	☐
Cold Sores/Fever Blisters	☐	Heart Murmur	☐	Pain in Jaw Joint	☐	Ulcers	☐
Congenital Heart Disorder	☐	Heart Pacemaker	☐	Parathyroid Disease	☐	Venereal Disease	☐
Convulsions	☐	Heart Trouble/Disease	☐	Psychiatric Care	☐	Yellow Jaundice	☐

Explain:____

Are you allergic to any of the following?

Aspirin	☐	Acrylic	☐
Penicillin	☐	Metal	☐
Codeine	☐	Latex	☐
Local Anesthetics	☐	Sulfa Drugs	☐

Other ☐

If yes, please explain:

- **Are you under a physician's care now? Y/N**

If yes, please explain: ______________________

- **Have you ever been hospitalized or had a major operation? Y/N**

If yes, please explain: ______________________

- **Have you ever had a serious head or neck injury? Y/N**

If yes, please explain: ______________________

- **Are you taking any medications, pills, or drugs? Y/N**

If yes, please explain: ______________________

- **Do you take, or have you taken, Phen-Fen or Redux? Y/N**

If yes, please explain: ______________________

- **Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y/N**

If yes, please explain: ______________________

- **Are you on a special diet?** Yes No
- **Do you use tobacco?** Yes No
- **Do you use controlled substances?** Yes No

Women, are you:

Pregnant/Trying to get pregnant? **Y/N**

Taking oral contraceptives? **Y/N**

Nursing? **Y/N**

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 my 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____________