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 answer the following questions.

Are you under a physician's care now?	OYes	ONo	If yes
Have you ever been hospitalized or had a major operation>	OYes	ONo	If yes
Have you ever had a serious head or neck injury?	OYes	ONo	If yes
Are you taking any medications, pills, or drugs?	OYes	ONo	If yes
Do you take, or have you taken, Phen-Fen or Redux?	OYes	ONo	If yes
Have you ever taken Fosamax. Boniva, Actonel or any other medications containing bisphosphonates?	OYes	ONo	If yes
Are you on a special diet?	OYes	ONo	If yes
Do you use tobacco?	OYes	ONo	If yes

Women: Are you...

[ ] Pregnant/Trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptives?

Are you alergic to any of the following?

[ ] Aspirin	[ ] Penicillin	[ ] Codeine	[ ] Acrylic
[ ] Metal	[ ] Latex	[ ] Sulfa Drugs	[ ] Local Anesthetics

Do you use controlled substances?	OYes	ONo	If yes
Other?	OYes	ONo	If yes

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

AIDS/HN Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism Scarlet	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Fever Shingles	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble Spina	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Bifida	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Stomach/intestinal Disease	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tumors or Growths	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Ulcers	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Venereal Disease	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No		
Yellow Jaundice	O Yes O No						

Have you ever had any serious illness not listed O Yes O 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:** _____