Medical History

Patient Name: ______________________________ **Birth Date:** ___________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 that you will receive. Thank you for answering the following questions.

Are you under a physician's care now? [ ]Yes [ ]No Physicians name: ______________________________
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 neck or head injury? [ ]Yes [ ]No
If yes, please explain: ______________________________
Are you taking **any** medications, pills, or drugs? [ ]Yes [ ]No If yes, please **list**:
____

Do you **PREMEDICATE** with antibiotics for dental visits? [ ]Yes [ ]No
Do you take or have you **EVER** taken Phen-Fen or Redux? [ ]Yes [ ]No
Have you **EVER** taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? [ ]Yes [ ]No
Do you take aspirin daily? [ ]Yes [ ]No
Do you use controlled substances? [ ]Yes [ ]No

Women: Are you pregnant or trying to get pregnant? [ ]Yes [ ]No
Taking oral contraceptives? [ ]Yes [ ]No Nursing? [ ]Yes [ ]No

Are you allergic to any of the following? [ ]Aspirin [ ]Penicillin [ ]Latex [ ]Codeine [ ]Acrylic [ ]Metal [ ]Local Anesthetics [ ]Sulfa Drugs
[ ]Other – Please list: ______________________________ **No known allergies** [ ]

Do you have, or have you **EVER** had, any of the following:

[ ]Yes [ ]No AIDS/HIV Positive
[ ]Yes [ ]No Heart Trouble/Disease
[ ]Yes [ ]No Hepatitis B or C
[ ]Yes [ ]No Rheumatic Fever
[ ]Yes [ ]No Arthritis/Gout
[ ]Yes [ ]No Excessive Bleeding
[ ]Yes [ ]No Sickle Cell Disease
[ ]Yes [ ]No Blood Disease
[ ]Yes [ ]No Blood Transfusion
[ ]Yes [ ]No Frequent Headaches
[ ]Yes [ ]No Low Blood Pressure
[ ]Yes [ ]No Thyroid Disease
[ ]Yes [ ]No Chest Pains
[ ]Yes [ ]No Fever Blisters
[ ]Yes [ ]No Parathyroid Disease
[ ]Yes [ ]No Alzheimer's Disease
[ ]Yes [ ]No Artificial Heart Valve
[ ]Yes [ ]No Breathing Problems
[ ]Yes [ ]No Heart Murmur

[ ]Yes [ ]No Cortisone Medicine
[ ]Yes [ ]No Hepatitis A
[ ]Yes [ ]No Renal Dialysis
[ ]Yes [ ]No Angina
[ ]Yes [ ]No Epilepsy or Seizures
[ ]Yes [ ]No Hives or Rash
[ ]Yes [ ]No Asthma
[ ] Yes [ ]No Frequent Cough
[ ]Yes [ ]No Frequent Diarrhea
[ ]Yes [ ]No Liver Disease
[ ]Yes [ ]No Swelling Limbs
[ ]Yes [ ]No Chemotherapy
[ ]Yes [ ]No Heart Attack/Failure
[ ]Yes [ ]No Pain in Jaw or Joints
[ ]Yes [ ]No Venereal Disease
[ ]Yes [ ]No Drug Addiction
[ ]Yes [ ]No Hypoglycemia
[ ]Yes [ ]No Genital Herpes
[ ]Yes [ ]No Heart Pacemaker

[ ]Yes [ ]No Hemophilia
[ ]Yes [ ]No Recent Weight Loss
[ ]Yes [ ]No Anemia
[ ]Yes [ ]No Emphysema
[ ]Yes [ ]No High Cholesterol
[ ]Yes [ ]No Shingles
[ ]Yes [ ]No Fainting Spells
[ ]Yes [ ]No Kidney Problems
[ ]Yes [ ]No Leukemia
[ ]Yes [ ]No Stroke
[ ]Yes [ ]No Cancer
[ ]Yes [ ]No Hay Fever
[ ]Yes [ ]No Osteoporosis
[ ]Yes [ ]No Tumors or Growths
[ ]Yes [ ]No Convulsions
[ ]Yes [ ]No Herpes
[ ]Yes [ ]No Sinus Trouble
[ ]Yes [ ]No Lung Disease
[ ]Yes [ ]No Diabetes

[ ]Yes [ ]No Radiation Treatments
[ ]Yes [ ]No Anaphylaxis
[ ]Yes [ ]No Easily Winded
[ ]Yes [ ]No High Blood Pressure
[ ] Yes [ ]No Scarlet Fever
[ ]Yes [ ]No Excessive Thirst
[ ]Yes [ ]No Irregular Heartbeat
[ ]Yes [ ]No Psychiatric Care
[ ]Yes [ ]No Bruise Easily
[ ]Yes [ ]No Glaucoma
[ ]Yes [ ]No Mitral Valve Prolapse
[ ]Yes [ ]No Tuberculosis
[ ]Yes [ ]No Congenital Heart Disease
[ ]Yes [ ]No Yellow Jaundice
[ ]Yes [ ]No Rheumatism
[ ]Yes [ ]No Spina Bifida
[ ]Yes [ ]No Tonsillitis
[ ]Yes [ ]No Stomach Disease
[ ]Yes [ ]No Tobacco use

Do you have an **artificial joint**? If so, **when**? ______________________________ **Where? Hip** [ ] **Knee** [ ] **Other** [ ]

Have you ever had ANY serious illness not listed above? [ ]Yes [ ]No
____

Is there any other special information that might help us with your dental visit including mental, emotional, or physical needs?
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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: ______________________________ **Date:** ____/____/__________