Medical History

Are you currently under a physician's care? **Y N**
Please Explain _____
Name of Physician _____
Physician's Address _____

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 list all:_____
Do you take or have you taken, Phen Fen or Redux?	**Y**	**N**	_____
Have you ever taken Fosamax, Boniva, Actonel or any other meds containing bisphosphonates?	**Y**	**N**	
Are you on a special diet?	**Y**	**N**	What Kind?_____
Do you use tobacco (includes E-cigarettes)?	**Y**	**N**	What Kind?_____ How Much?_____
Do you use or have you used controlled substances?	**Y**	**N**	
Have you ever been diagnosed with MRSA , VRSA, VRE, or CDIF?	**Y**	**N**	

Women- Are You:

Pregnant/Trying to get pregnant?	**Y**	**N**
Nursing?	**Y**	**N**
Take oral contraceptives?	**Y**	**N**

Are you allergic to OR have you had any reaction to the following?

Aspirin	**Y**	**N**	Metal	**Y**	**N**
Penicillin	**Y**	**N**	Latex	**Y**	**N**
Codeine	**Y**	**N**	Sulfa Drugs	**Y**	**N**
Acrylic	**Y**	**N**	Local Anesthetics	**Y**	**N**

Other_____

Do you have, OR have you had, any of the following:

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

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

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 my medical status.

Signature of Patient, Parent, or Guardian _____ **Date** _____