# MEDICAL HISTORY

*Although dental personnel primarily treat the area in and around your mouth, it is an extremely important 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.*
*Please answer the following questions:*

Are you under a physician's care now? Y/N If Yes, explain: _____
Have you ever had been hospitalized/ major operation? Y/N If Yes, explain: _____
Have you ever had a serious head or neck injury? Y/N If Yes, explain: _____
Are you taking any medications, pills or drugs? Y/N If Yes, explain: _____
Do you take, or have you taken, Phen-fen or Redux? Y/N If Yes, explain: _____
Have you ever taken Fosamax, Boniva, Actonel or other medications containing bisphosphonates? Y/N If Yes, explain: _____
Are you on a special diet? Y/N If Yes, explain: _____
Do you use tobacco? Y/N If Yes, explain: _____
Do you use controlled substances? Y/N If Yes, explain: _____
Other/Notes: _____
_____

**Woman**: Are you:

- ☐ Pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives
- ☐ Trying to Conceive

Are you allergic to any of the following?

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

Other : _____

***PLEASE CIRCLE IF YOU HAVE OR HAVE HAD, ANY OF THE FOLLOWING?***

- ☐ **AIDS/HIV POSITIVE**
- ☐ **Alzheimer's Disease**
- ☐ **Anaphylaxis**
- ☐ **Anemia**
- ☐ **Arthritis/Gout**
- ☐ **Artificial Heart Valve**
- ☐ **Artificial Joint**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Blood transfusion**
- ☐ **Breathing Problem**
- ☐ **Bruise Easily**
- ☐ **Cancer**
- ☐ **Chemotherapy**
- ☐ **Chest Pain**
- ☐ **Cold Sores/Fever blister**
- ☐ **Congenital Heart Disorder**
- ☐ **Convulsion**
- ☐ **Cortisone Medicine**
- ☐ **Diabetes**
- ☐ **Drug Addiction**
- ☐ **Easily Winded**
- ☐ **Emphysema**
- ☐ **Epilepsy or Seizures**
- ☐ **Breathing Difficulty**
- ☐ **Excessive bleeding**
- ☐ **Excessive thirst**
- ☐ **Fainting Spells/Dizziness**
- ☐ **Frequent Cough**
- ☐ **Frequent Diarrhea**
- ☐ **Frequent Headaches**
- ☐ **Genital Herpes**
- ☐ **Glaucoma**
- ☐ **Hay Fever**
- ☐ **Heart Attack/Failure**
- ☐ **Heart Murmur**
- ☐ **Heart Pace Maker**
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problem
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joint
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Fever
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/intestinal
- ☐ Disease
- ☐ Stroke
- ☐ Sulfa
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes / No

***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. <u>It is my responsibility to inform the dental office of any changes in medical status</u>***

_____ _____
Patient/Guardian Signature Date

_____ _____
Doctor/Staff Signature Date