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 answering the following questions.

Are you under a physician's care now? Yes No 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 head or neck injury? Yes No If yes, please explain: Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No Are you on a special diet? Yes No No Do you use tobacco? Yes No Women: Are you Pregnant/Trying to get pregnant? Yes No Nursing? Yes No		
Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Other If yes, please explain:	Acrylic Metal	Latex Sulfa drugs
Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Angina Yes No Arthritis/Gout Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Asthma Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problem Yes No Bruise Easily Yes No Chemotherapy Yes No Concer Yes No Conser/Fever Blisters Yes No Conser/Fever Blisters Yes No Congenital Heart Disorder Yes No Heart Attack/Failure Yes No Congenital Heart Disorder Yes No Heart Pacem	Hemophilia Yes No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure Yes No High Cholesterol Yes No High Cholesterol Yes No Hives or Rash Yes No Hypoglycemia Yes No Irregular Heartbeat Yes No Kidney Problems Yes No Leukemia Yes No Liver Disease Yes No Lung Disease Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Parathyroid Disease Yes No Psychiatric Care Yes No	Radiation Treatments Yes No Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Shingles Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tuberculosis Yes No Tulers or Growths Yes No Venereal Disease Yes No Yellow Jaundice 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. It is my responsibility to inform the dental office of any changes in medical status.