MEDICAL HISTORY

Patient Name_____

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.

Have you ever been hospitalized or had a major operation? o Yes o No
Have you ever had a serious head, neck or jaw injury? o Yes o No
Please list any Rx, Over the Counter and/or supplemental medications you are currently taking:

_____
_____
_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? o Yes o No
Do you take, or have you taken, Phen-Fen or Redux? o Yes o No
Are you on a special diet? o Yes o No
Women: Are you pregnant/Trying to get pregnant? o Nursing? o Taking oral contraceptives? o

Are you allergic to or had an adverse reaction to any of the following?
o Aspirin o Penicillin o Codeine o Sulfa o Acrylic o Metal o Latex o Local Anesthetics o Other_____

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

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

* Condition may require pre-treatment medication

Have you ever had any serious illness not listed above? o Yes o No
Comments_____
Do you have any dental concerns? _____
Are you apprehensive about dental treatment? o Yes o No
Have you ever been told you grind or clench your teeth? o Yes o 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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT or GUARDIAN DATE

rev. 04-15