## **MEDICAL HISTORY**

PATIENT	

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		If yes, please explain:			
Have you ever had a serious head or neck injury? $\bigcirc$ Yes $\bigcirc$ 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, P	hen-Fen or Redux? 🔿 Yes 🔿 No				
Have you ever taken Fosamay, Boniva, Actonel or any					
other medications containing bisphosphonates? Yes No					
Are yo	u on a special diet? $\bigcirc$ Yes $\bigcirc$ No				
D	o you use tobacco? 🔘 Yes 🔵 No				
Do you use controlled substances? O Yes O No					
Women: Are you					
Pregnant/Trying to get pregnant?	Yes No Taking oral contrace	ptives? Yes No Nursing?	○ Yes ○ No		
Are you allergic to any of the following?					
Aspirin Penicillin	Codeine Local Anesthetic	s Acrylic Metal	Latex Sulfa drugs		
Other If yes, please explain:					
	f the following?				
Do you have, or have you had, any o	-				
AIDS/HIV Positive () Yes () No Alzheimer's Disease () Yes () No	Cortisone Medicine () Yes () No Diabetes () Yes () No	Hemophilia Yes No   Hepatitis A Yes No	Radiation Treatments   Yes   No     Recent Weight Loss   Yes   No		
Anaphylaxis (Yes No	Drug Addiction	Hepatitis B or C Yes No	Renal Dialysis		
Anemia	Easily Winded () Yes () No	Herpes O Yes O No	Rheumatic Fever		
Angina O Yes O No	Emphysema O Yes O No	High Blood Pressure () Yes () No	Rheumatism		
Arthritis/Gout	Epilepsy or Seizures O Yes O No	High Cholesterol O Yes O No	Scarlet Fever OYes ONo		
Artificial Heart Valve O Yes O No	Excessive Bleeding O Yes O No	Hives or Rash O Yes No	Shingles		
Artificial Joint O Yes O No	Excessive Thirst O Yes O No	Hypoglycemia O Yes O No	Sickle Cell Disease O Yes O No		
Asthma O Yes O No	Fainting Spells/Dizziness O Yes O No	Irregular Heartbeat OYes No	Sinus Trouble OYes No		
Blood Disease O Yes O No	Frequent Cough 🛛 Yes 🔿 No	Kidney Problems OYes No	Spina Bifida 🔿 Yes 🔿 No		
Blood Transfusion O Yes O No	Frequent Diarrhea OYes ONo	Leukemia 💛 Yes 🔿 No	Stomach/Intestinal Disease O Yes O No		
Breathing Problem O Yes O No	Frequent Headaches O Yes O No	Liver Disease O Yes O No	Stroke OYes No		
Bruise Easily Ores Oregonia	Genital Herpes OYes ONo	Low Blood Pressure O Yes O No	Swelling of Limbs O Yes O No		
Cancer O Yes O No	Glaucoma O Yes O No	Lung Disease O Yes O No	Thyroid Disease O Yes No		
Chemotherapy O Yes O No	Hay Fever O Yes O No	Mitral Valve Prolapse O Yes O No	Tonsillitis () Yes () No Tuberculosis () Yes () No		
Chest Pains O Yes O No	Heart Attack/Failure O Yes O No	Osteoporosis O Yes O No	Tuberculosis Yes No   Tumors or Growths Yes No		
Cold Sores/Fever Blisters O Yes O No	Heart Murmur () Yes () No	Pain in Jaw Joints O Yes O No			
Congenital Heart Disorder Ves No	Heart Pacemaker O Yes O No	Parathyroid Disease O Yes O No	Venereal Disease		
Convulsions () Yes () No	Heart Trouble/Disease O Yes O No	Psychiatric Care Yes No	Yellow Jaundice O Yes O No		
Have you ever had any serious illness not listed above? Yes No					
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 medical status.