Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Heath problems that you may have, or medication(s) that you may be taking, could have an important interrelationship with dentistry you will receive. Thank you for answering the following questions.

Please circle all that apply Yes or No

Are you under a physician's care now: Yes/No if yes explain: _____
Have you ever been hospitalized or had a major operation? Yes/No If yes explain: _____
Have you ever had a serious head or neck injury? Yes/No If yes explain: _____
Are you taking any medications, pills or drugs? Yes/No If yes explain: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes/No If yes explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any Other medications containing bisphosphonates? Yes/No _____
Are you on a special diet? Yes/No
Do you use tobacco? Yes/No
Do you use controlled substances? Yes/No

Women: Are you: Pregnant/Trying to get pregnant? Yes/No Taking oral contraceptives? Yes/No Nursing: Yes/No

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex ☐ Acrylic ☐ Sulfa drugs☐
Metal☐ Other ☐ If yes, please explain: _____

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

Please circle Yes or No for all that may apply to your health history. Thank you.

AIDS/HIV Positive	Yes/No	Cortisone Medicine	Yes/No	Hemophilia	Yes/No	Radiation Treatments	Yes/No
Alzheimer's Disease	Yes/No	Diabetes	Yes/No	Hepatitis A	Yes/No	Recent Weight Loss	Yes/No
Anaphylaxis	Yes/No	Drug Addiction	Yes/No	Hepatitis B	Yes/No	Renal Dialysis	Yes/No
Anemia	Yes/No	Easily Winded	Yes/No	Herpes	Yes/No	Rheumatic Fever	Yes/No
Angina	Yes/No	Emphysema	Yes/No	High Blood	Yes/No	Rheumatism	Yes/No
Arthritis/Gout	Yes/No	Epilepsy or Seizures	Yes/No	High Chest	Yes/No	Scarlet Fever	Yes/No
Artificial Heart Valve	Yes/No	Excessive Bleeding	Yes/No	Hives/Rash	Yes/No	Shingles	Yes/ No
Asthma	Yes/No	Fainting/Dizziness	Yes /No	Hypoglycemia	Yes/No	Sinus Trouble	Yes/No
Blood Disease	Yes/No	Frequent Cough	Yes/No	Kidney Problems	Yes/No	Spina Bifida	Yes/No
Blood Transfusion	Yes/No	Frequent Diarrhea	Yes/No	Leukemia	Yes/No	Stomach Disease	Yes/No
Breathing Problems	Yes/No	Frequent Headaches	Yes/No	Liver Disease	Yes/No	Stroke	Yes/No
Bruise Easily	Yes/No	Genital Herpes	Yes/No	Low Blood Press	Yes/No	Swelling of Limbs	Yes/No
Cancer	Yes/No	Glaucoma	Yes/No	Lung Disease	Yes/No	Thyroid Disease	Yes/No
Chemotherapy	Yes/No	Hay Fever	Yes/No	Mitral Valve Prolapse	Yes/No	Tonsillitis	Yes/No
Chest Pain	Yes/No	Heart Attack/Failure	Yes/No	Osteoporosis	Yes/No	Tuberculosis	Yes/No
Cold Sore/FeverBlister	Yes/No	Heart Murmur	Yes/No	Pain in Jaw Joints	Yes/No	Tumors or Growths	Yes/No
Congenital Heart	Yes/No	Heart Pacemaker	Yes/No	Parathyroid Disease	Yes/No	Venereal Disease	Yes/No
Convulsions	Yes/No	Heart Trouble	Yes/No	Psychiatric Care	Yes/No	Yellow Jaundice	Yes/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 health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient/Legal Guardian **Date**