MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

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 currently have, previously had, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? **Y N** If yes, please explain: _____
Have you been hospitalized or had a major operation? **Y N** If yes, please explain: _____
Have you had a serious head or neck injury? **Y N** If yes, please explain: _____
Are you taking any medications, pills, or drugs? **Y N** If yes , please explain: _____
Do you/have you taken Phen-Fen or Redux? **Y N** _____
Have you taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? **Y N**
Are you on a special diet? **Y N** If yes, please explain: _____
Do you use tobacco? **Y N** If yes, please explain: _____
Do you use controlled substances? **Y N** If yes, please explain: _____
WOMEN: ARE YOU: ___ pregnant/trying to get pregnant? ____taking oral contraceptives? ____Nursing?

Are you allergic to any of the following?

____ Aspirin	____ Local Anesthetics	____ Latex	____ Codeine
____ Penicillin	____ Acrylic	____ Sulfa Drugs	____ Metal

____ Other: please explain: _____

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

__ AIDS/HIV positive	__ Congenital Heart Disorder	__ Heart Trouble/Disease	__ Psychiatric Care
__ Alzheimer's Disease	__ Convulsions	__ Hemophilia	__ Weight Loss
__ Anaphylaxis	__ Cortisone Medicine	__ Hepatitis A, B, C	__ Renal Dialysis
__ Anemia	__ Diabetes	__ Herpes	__ Rheumatic Fever
__ Angina	__ Drug Addiction	__ High Blood Pressure	__ Rheumatism
__ Arthritis/Gout	__ Easily Winded	__ High Cholesterol	__ Scarlet Fever
__ Artificial/Heart Valve	__ Emphysema	__ Hives or Rash	__ Shingles
__ Artificial Joint	__ Epilepsy/Seizures	__ Hypoglycemia	__ Sickle Cell Disease
__ Asthma	__ Excessive Bleeding	__ Irregular Heartbeat	__ Sinus Trouble
__ Blood Disease	__ Fainting Spells/Dizziness	__ Kidney Problems	__ Spina Bifida
__ Blood Transfusion	__ Frequent Cough/Headaches	__ Leukemia	__ Stroke
__ Breathing Problem	__ Frequent Diarrhea	__ Liver Disease	__ Stomach Disease
__ Cancer	__ Glaucoma	__ Low Blood Pressure	__ Swelling of Limbs
__ Chemotherapy	__ Hay Fever	__ Lung Disease	__ Thyroid Disease
__ Chest Pains	__ Heart Attack/Failure	__ Osteoporosis	__ Tonsillitis
__ Cold Sores/Fever Blisters	__ Heart Murmur/Pacemaker	__ Parathyroid Disease	__ Tumors/Ulcers

__ Not listed above? Please explain: _____

~ 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.

Signature of Patient, Parent, or Guardian: _____ Date: _____