MEDICAL HISTORY

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 may react to the dental procedure being administered.

Are you under a physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes _____

Do you take, or have taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes _____

Are you on a special diet? ☐ Yes ☐ No If yes _____

Do you use tobacco products? ☐ Yes ☐ No If yes _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to the following?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other? If yes _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

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

AIDS/HIV Positive	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
				Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes _____

To the best of my knowledge, the questions on the 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; X _____ **Date** _____