Date:_____

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 have, or medications you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If yes, please explain:

Are you under a physician's care now? ◯ Yes ◯ No _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No _____

Do you take any medications, pills, or drugs? ◯ Yes ◯ No Please list: _____

_____

_____

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

Do you use tobacco? ◯ Yes ◯ No If yes, how long?_____

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 ◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Other_____

Please check if you have, or have you had, any of the following?

- ◯ Aids/HIV positive
- ◯ Anaphylaxis
- ◯ Anemia
- ◯ Angina
- ◯ Arthritis/Gout
- ◯ Artificial Heart Valve
- ◯ Artificial Joint
- ◯ Asthma
- ◯ Breathing Problem
- ◯ Bruise Easily
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Chest Pains
- ◯ Congenital Heart Disorder
- ◯ Convulsions
- ◯ Cortisone Medicine
- ◯ Diabetes:
  Last HbA1c?_____
- ◯ Drug Addiction
- ◯ Emphysema
- ◯ Epilepsy or Seizures
- ◯ Excessive Bleeding
- ◯ Excessive Thirst
- ◯ Fainting Spells/Dizziness
- ◯ Frequent Cough
- ◯ Glaucoma
- ◯ Hay Fever
- ◯ Heart Attack/Failure
- ◯ Heart Pacemaker
- ◯ Heart Trouble/Disease
- ◯ Hemophilia
- ◯ Hepatitis A
- ◯ Hepatitis B or C
- ◯ Herpes
- ◯ High Blood Pressure
- ◯ Hives or Rash
- ◯ Hypoglycemia
- ◯ Irregular Heartbeat
- ◯ Kidney Problems
- ◯ Leukemia
- ◯ Liver Disease
- ◯ Low Blood Pressure
- ◯ Osteoporosis
- ◯ Radiation Treatment
- ◯ Recent Unexplained Weight Loss
- ◯ Rheumatic Fever/Scarlet Fever
- ◯ Sinus Trouble
- ◯ Stomach/Intestinal Disease
- ◯ Stroke
- ◯ Swelling of Limbs
- ◯ Thyroid Disease
- ◯ Tonsillitis
- ◯ Tuberculosis
- ◯ Tumors or Growths
- ◯ Ulcers
- ◯ Yellow Jaundice

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.

_____ _____

Signature of Patient, Parent, or Guardian Date