

MEDICAL HISTORY

PATIENT NAME _____ 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 a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes 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, Phen-Fen or Redux? Yes No _____

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

Are you on a special diet? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Nursing?

Do you use tobacco? Yes No

Taking oral contraceptives?

Do you use controlled substances? Yes No

Are you allergic to any of the following? _____

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Local Anesthetics

Sulfa Drugs

Other

If yes, please explain: _____

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

AIDS/HIV Positive

Chest Pains

Frequent Headaches

Hypoglycemia

Rheumatic Fever

Alzheimer's Disease

Cold Sores/Fever Blisters

Genital Herpes

Irregular Heartbeat

Rheumatism

Anaphylaxis

Congenital Heart Disorder

Glaucoma

Kidney Problems

Scarlet Fever

Anemia

Convulsions

Hay Fever

Leukemia

Shingles

Angina

Cortisone Medicine

Heart Attack/Failure

Liver Disease

Sickle Cell Disease

Arthritis/Gout

Diabetes

Heart Murmur

Low Blood Pressure

Sinus Trouble

Artificial Heart Valve

Drug Addiction

Heart Pacemaker

Lung Disease

Spina Bifida

Artificial Joint

Easily Winded

Heart Trouble/Disease

Mitral Valve Prolapse

Stroke

Asthma

Emphysema

Hemophilia

Osteoporosis

Swelling of Limbs

Blood Disease

Epilepsy or Seizures

Hepatitis A

Pain in Jaw Joints

Thyroid Disease

Blood Transfusion

Excessive Bleeding

Hepatitis B or C

Parathyroid Disease

Tonsillitis

Breathing Problem

Excessive Thirst

Herpes

Psychiatric Care

Tuberculosis

Bruise Easily

Fainting Spells/Dizziness

High Blood Pressure

Radiation Treatments

Tumors or Growths

Cancer

Frequent Cough

High Cholesterol

Recent Weight Loss

Ulcers

Chemotherapy

Frequent Diarrhea

Hives or Rash

Renal Dialysis

Venereal Disease

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

If you have sleep apnea, please answer the following questions:

1. Do you snore? _____

2. Do you want the sleep physician and dentist to contact you about your snoring and sleep apnea? _____

3. Do you wear a CPAP? _____

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 _____