## **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	<u> </u>		
other medications containing bisphospho	nates? Ves Vo -		
Are you on a special diet? () Yes () No			
	~ ~		
Do you use tobacco? ◯ Yes ◯ No Do you use controlled substances? ◯ Yes ◯ No			
-			
Women: Are you	Tabian and contracent		
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	Acrylic Metal	Latex Sulfa drugs
Other If yes, please explain:			
Do you have, or have you had, any of the following			
AIDS/HIV Positive () Yes () No Cortisone M	<u> </u>	Hemophilia () Yes () No	Radiation Treatments O Yes O No
Alzheimer's Disease Yes No Diabetes		Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis () Yes () No Drug Addicti	ă ă	Hepatitis B or C Yes No	Renal Dialysis () Yes () No
Anemia OYes No Easily Windo	ě ě	Herpes () Yes () No	Rheumatic Fever OYes No
Angina () Yes () No Emphysema	ă ă	High Blood Pressure () Yes () No	Rheumatism () Yes () No
Arthritis/Gout () Yes () No Epilepsy or S	ě č	High Cholesterol () Yes () No	Scarlet Fever () Yes () No
Artificial Heart Valve Ves No Excessive B	° č č	Hives or Rash () Yes () No	Shingles Yes No
Artificial Joint Oregon Ves No Excessive T	ě ě	Hypoglycemia () Yes () No	Sickle Cell Disease Yes No
	Ils/Dizziness () Yes () No	Irregular Heartbeat () Yes () No	Sinus Trouble () Yes () No
Blood Disease O Yes No Frequent Co	•	Kidney Problems O Yes O No	Spina Bifida () Yes () No
Blood Transfusion O Yes No Frequent Dia		Leukemia 💛 Yes 🚫 No	Stomach/Intestinal Disease O Yes O No
Breathing Problem OYes No Frequent He	0 0	Liver Disease () Yes () No	Stroke O Yes O No
Bruise Easily OYes No Genital Herp	es 🛛 🔿 Yes 🔾 No	Low Blood Pressure 🔘 Yes 🔵 No	Swelling of Limbs O Yes O No
Cancer OYes No Glaucoma	🔿 Yes 🔿 No	Lung Disease 🛛 🔿 Yes 🔿 No	Thyroid Disease O Yes O No
Chemotherapy O Yes O No Hay Fever	🔿 Yes 🔿 No	Mitral Valve Prolapse 🔘 Yes 🔘 No	Tonsillitis Yes No
Chest Pains OYes No Heart Attack	/Failure 🛛 Yes 🔾 No	Osteoporosis 🛛 Yes 🔾 No	Tuberculosis Yes No
Cold Sores/Fever Blisters Ves No Heart Murme	ır 🛛 Yes 🔾 No	Pain in Jaw Joints 🛛 Yes 🔾 No	Tumors or Growths () Yes () No Ulcers () Yes () No
Congenital Heart Disorder Yes No Heart Pacen	naker 🔿 Yes 🔿 No	Parathyroid Disease 🔘 Yes 🔘 No	Venereal Disease Venereal Venereal Disease Venereal Venereal Disease Venereal Venere
Convulsions O Yes No Heart Trouble	e/Disease 🔿 Yes 🔿 No	Psychiatric Care OYes ONo	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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.