Medical History

Patient Name: ________________________________ **Date of Birth:** ____________________ **Today's Date:** ________________

Although dental personnel primarily treat the area in and around your mouth, it is 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:

Question			
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 surgery?	○ YES ○ NO	If Yes	
Are you taking any medications, pills or drugs?	○ YES ○ NO	If Yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ YES ○ NO	If Yes	
Do you require Premedication (Antibiotic) prior to your dental appointment?	○ YES ○ NO	If Yes	
Do you use tobacco? Smokeless? How often?	○ YES ○ NO	If Yes	

Women Are You… ☐ Pregnant/Trying to Get Pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are You Allergic to Any of the Following?

Acrylic	○Yes ○No	Aspirin	○Yes ○No	Codeine	○Yes ○No	Latex	○Yes ○No
Local Anesthetic	○Yes ○No	Metal	○Yes ○No	Penicillin	○Yes ○No	Sulfa Drugs	○Yes ○No

Do You Have, or Have You Had, Any of the Following?

Aids/HIV Positive	○Yes ○No	Alzheimer's Disease	○Yes ○No	Anemia	○Yes ○No	Angina	○Yes ○No
Arthritis/Gout	○Yes ○No	Artificial Heart Valve	○Yes ○No	Artificial Joint	○Yes ○No	Asthma	○Yes ○No
Blood Disease	○Yes ○No	Breathing Problems	○Yes ○No	Bruise Easily	○Yes ○No	Cancer	○Yes ○No
Chemotherapy	○Yes ○No	Chest Pains	○Yes ○No	Cold Sores/Blisters	○Yes ○No	Congenital Heart Disorder	○Yes ○No
Convulsions/Seizures	○Yes ○No	Diabetes	○Yes ○No	Dialysis	○Yes ○No	Drug Addiction	○Yes ○No
Epilepsy & Seizures	○Yes ○No	Excessive Bleeding	○Yes ○No	Excessive Thirst	○Yes ○No	Fainting/Dizziness	○Yes ○No
Frequent Cough	○Yes ○No	Frequent Diarrhea	○Yes ○No	Frequent Headaches	○Yes ○No	Hay Fever	○Yes ○No
Heart Attack/Failure	○Yes ○No	Heart Murmur	○Yes ○No	Heart Pacemaker	○Yes ○No	Heart Trouble/Disease	○Yes ○No
Hemophilia	○Yes ○No	Hepatitis A	○Yes ○No	Hepatitis B or C	○Yes ○No	Herpes	○Yes ○No
High Blood Pressure	○Yes ○No	High Cholesterol	○Yes ○No	Hives or Rash	○Yes ○No	Hypoglycemia	○Yes ○No
Irregular Heartbeat	○Yes ○No	Kidney Problems	○Yes ○No	Leukemia	○Yes ○No	Liver Disease	○Yes ○No
Low Blood Pressure	○Yes ○No	Mitral Valve Prolapse	○Yes ○No	Organ Transplant	○Yes ○No	Osteoporosis	○Yes ○No
Pain in Jaw Joints	○Yes ○No	Radiation Treatment	○Yes ○No	Rheumatic Fever	○Yes ○No	Scarlet Fever	○Yes ○No
Sickle Cell Disease	○Yes ○No	Spina Bifida	○Yes ○No	Stroke	○Yes ○No	Thyroid Disease	○Yes ○No
Tonsillitis	○Yes ○No	Tuberculosis	○Yes ○No	Ulcers	○Yes ○No	Other: ______________	○Yes ○No

Do You Have Any Other Illness Not Listed: ○ YES ○ NO If Yes:

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.

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Signature of Patient, Parent, Legal Guardian **Date**