

Medical History (Copy)

Patient Name:

Birth Date:

Date Created:

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, c

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 you 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? Yes No If yes

Do you use controlled substances? Yes No If yes

Do you clench or grind your teeth? Yes No If yes

Do you have difficulty breathing at night? Yes No If yes

Have you ever or currently use a CPAP? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Other?

If yes

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

- AIDS/HIV Positive Yes No
- Alzheimer's Disease Yes No
- Anaphylaxis 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
- Blood Transfusion Yes No
- Breathing Problems Yes No
- Bruise Easily Yes No
- Cancer Yes No
- Chemotherapy Yes No
- Chest Pains Yes No
- Cold Sores/Fever Blisters Yes No
- Congenital Heart Disorder Yes No
- Convulsions Yes No
- Yellow Jaundice Yes No

- Cortisone Medicine Yes No
- Diabetes Yes No
- Drug Addiction Yes No
- Easily Winded Yes No
- Emphysema Yes No
- Epilepsy or Seizures Yes No
- Excessive Bleeding Yes No
- Excessive Thirst Yes No
- Fainting Spells/Dizziness Yes No
- Frequent Cough Yes No
- Frequent Diarrhea Yes No
- Frequent Headaches Yes No
- Genital Herpes Yes No
- Glaucoma Yes No
- Hay Fever Yes No
- Heart Attack/Failure Yes No
- Heart Murmur Yes No
- Heart Pacemaker Yes No
- Heart Trouble/Disease Yes No
- Sleep Apnea 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
- Lung Disease Yes No
- Mitral Valve Prolapse Yes No
- Osteoporosis Yes No
- Pain in Jaw Joints Yes No
- Parathyroid Disease Yes No
- Psychiatric Care Yes No

- Radiation Treatments Yes No
- Recent Weight Loss Yes No
- Renal Dialysis Yes No
- Rheumatic Fever Yes No
- Rheumatism Yes No
- Scarlet Fever Yes No
- Shingles Yes No
- Sickle Cell Disease Yes No
- Sinus Trouble Yes No
- Spina Bifida Yes No
- Stomach/Intestinal Disease Yes No
- Stroke Yes No
- Swelling of Limbs Yes No
- Thyroid Disease Yes No
- Tonsillitis Yes No
- Tuberculosis Yes No
- Tumors or Growths Yes No
- Ulcers Yes No
- Venereal Disease Yes No

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

Are you required to premedicate prior to your appointment? 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.

Signature of Patient, Parent or Guardian:

X

Date: _____