

## Medical History

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone Number: (W) \_\_\_\_\_

Email Address: \_\_\_\_\_ (C) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth 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 questions.

- Are you currently under a physician's care?  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: \_\_\_\_\_
- Have you ever taken Fosamax, Bonica, Actonel, or any medication containing bisphosphonates?  Yes  No If yes: \_\_\_\_\_
- Do you use tobacco?  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

Other: \_\_\_\_\_

None

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

AIDS/HIV Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive Thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells/Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack/Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble/Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis B or C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in Jaw Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Radiation Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sickle Cell Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tonsilitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tumors or Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Serious Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: \_\_\_\_\_