Medical History Form

Medical History

Patient First Name:	Patient Last Name:	DOB:	Signature of Patient, Parent or Guardian:	Date:
			Sign	

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 impor tant 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

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

Women: Are you...

- ☐ Taking oral contraceptives?
- ☐ Nursing?
- ☐ Pregnant/Trying to get pregnant?

Are you allergic to any of the following?

- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Metal
- ☐ Acrylic
- ☐ Codeine
- ☐ Penicillin
- ☐ Aspirin
- ☐ Local Anesthetics

Other?

☐ Yes

Comment

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

	Yes	No
High Cholesterol	○	○
Osteoporosis	○	○
Yellow Jaundice	○	○
Radiation Treatments		

	○	○
Venereal Disease	○	○
Ulcers	○	○
Tumors or Growths	○	○
Tuberculosis	○	○
Tonsillitis	○	○
Thyroid Disease	○	○
Swelling of Limbs	○	○
Stroke	○	○
Stomach/Intestinal Disease	○	○
Spina Bifida	○	○
Sinus Trouble	○	○
Sickle Cell Disease	○	○
Shingles	○	○
Scarlet Fever	○	○
Rheumatism	○	○
Rheumatic Fever	○	○
Renal Dialysis	○	○
Recent Weight Loss	○	○
Psychiatric Care	○	○
Parathyroid Disease	○	○
Pain in Jaw Joints	○	○
Mitral Valve Prolapse	○	○
Lung Disease	○	○
Low Blood Pressure	○	○
Liver Disease	○	○
Leukemia	○	○
Kidney Problems	○	○
Irregular Heartbeat	○	○
Hypoglycemia	○	○
Hives or Rash	○	○
AIDS/HIV Positive	○	○
High Blood Pressure	○	○
Herpes	○	○
Hepatitis B or C	○	○
Hepatitis A	○	○
Hemophilia	○	○
Heart Trouble/Disease	○	○
Heart Pacemaker	○	○
Heart Murmur	○	○
Heart Attack/Failure	○	○
Hay Fever	○	○
Glaucoma	○	○
Genital Herpes	○	○
Frequent Headaches	○	○
Frequent Diarrhea	○	○

Frequent Cough	○	○
Fainting Spells/Dizziness	○	○
Excessive Thirst	○	○
Excessive Bleeding	○	○
Epilepsy or Seizures	○	○
Emphysema	○	○
Easily Winded	○	○
Drug Addiction	○	○
Diabetes	○	○
Cortisone Medicine	○	○
Convulsions	○	○
Congenital Heart Disorder	○	○
Cold Sores/Fever Blisters	○	○
Chest Pains	○	○
Chemotherapy	○	○
Cancer	○	○
Bruise Easily	○	○
Breathing Problems	○	○
Blood Transfusion	○	○
Blood Disease	○	○
Asthma	○	○
Artificial Joint	○	○
Artificial Heart Valve	○	○
Arthritis/Gout	○	○
Angina	○	○
Anemia	○	○
Anaphylaxis	○	○
Alzheimer's Disease	○	○

Have you ever had any serious illness not listed above?

○ Yes ○ No

If Yes

Comments:

undefined

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.