PATIENT MEDICAL HISTORY

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.

Yes NO

___ ___ 1. Are you under physician's care now? If yes: _____
___ ___ 2. Have you been hospitalized or had a major operation? If yes:_____
___ ___ 3. Have you ever had a serious head or neck injury? If yes: _____
___ ___ 4. Are you taking any medications or drugs? If yes: _____
___ ___ 5. Do you take or have you taken Phen-Fen or Redux?
___ ___ 6. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?
___ ___ 7. Are you on a special diet?
___ ___ 8. Do you use tobacco?
___ ___ 9. Do you use controlled substances? If yes: _____

WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO

Are you allergic to any of the following?

__ Aspirin __ Penicillin __ Sulfa Drugs __ Codeine __ Acrylic/Metal __ Latex __ Anesthetics __ Other _____

Do you have or have you ever been told you have any of the following? (check all that apply)

__AIDS/HIV Positive
__Alzheimer's Disease
__Anaphylaxis
__Anemia
__Angina
__Arthritis/Gout
__Artificial Heart Valve
__Artificial Joint
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problems
__Bruise Easily
__Cancer
__Chemotherapy
__Chest pains
__Cold Sores/Fever Blisters
__Congenital Heart Disorder
__Convulsions
__Yellow Jaundice

__Cortisone Medicine
__Diabetes
__Drug Addiction
__Easily Winded
__Emphysema
__Epilepsy/Seizures
__Excessive Bleeding
__Excessive Thirst
__Fainting / Dizziness
__Frequent Cough
__Frequent Diarrhea
__Frequent Headaches
__Genital Herpes
__Glaucoma
__Hay Fever
__Heart Attack/Failure
__Heart Murmur
__Heart Pacemaker
__Heart Trouble/Disease

__Hemophilia
__Hepatitis A
__Hepatitis B or C
__Herpes
__High Blood Pressure
__High Cholesterol
__Hives or Rash
__Hypoglycemia
__Irregular Heartbeat
__Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Osteoporosis
__Pain in Jaw Joints
__Parathyroid Disease
__Psychiatric Care

__Radiation Treatments
__Recent Weight Loss
__Renal Dialysis
__Rheumatic Fever
__Rheumatism
__Scarlet Fever
__Shingles
__Sickle Cell Disease
__Sinus Trouble
__Spina Bifida
__Stomach/Intestine Disease
__Stroke
__Swelling of Limbs
__Thyroid Disease
__Tonsilitis
__Tuberculosis
__Tumors or Growths
__Ulcers
__Veneral Disease

Have you ever had any serious illness not listed above? 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.

_____ _____
Patient's Signature (Parent or Guardian) Date