MEDICAL HISTORY

PATIENT NAME: ______________________ BIRTH DATE: ______________________

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 you may be taking, could have an important interrelationship with the dentistry you will receive or will be able to receive. Thank you for answering the following questions.

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

Condition		Condition		Condition		Condition	
AIDS / HIV+	◯Yes ◯ No	Convulsions	◯Yes ◯ No	Hemophilia	◯Yes ◯ No	Psychiatric Care	◯Yes ◯ No
Alzheimers Disease	◯Yes ◯ No	Cortisone Medicine	◯Yes ◯ No	Hepatitis A	◯Yes ◯ No	Radiation Treatments	◯Yes ◯ No
Anaphylaxis	◯Yes ◯ No	Diabetes	◯Yes ◯ No	Hepatitis B or C	◯Yes ◯ No	Recent Weight Loss	◯Yes ◯ No
Anemia	◯Yes ◯ No	Easily Winded	◯Yes ◯ No	Herpes	◯Yes ◯ No	Renal Dialysis	◯Yes ◯ No
Angina	◯Yes ◯ No	Emphysema	◯Yes ◯ No	High Blood Pressure	◯Yes ◯ No	Rheumatic Fever	◯Yes ◯ No
Arthritis / Gout	◯Yes ◯ No	Epilepsy / Seizures	◯Yes ◯ No	High Cholesterol	◯Yes ◯ No	Rheumatism	◯Yes ◯ No
Artificial Heart Valve	◯Yes ◯ No	Excessive Bleeding	◯Yes ◯ No	Hives or Rash	◯Yes ◯ No	Scarlet Fever	◯Yes ◯ No
Artificial Joint	◯Yes ◯ No	Excessive Thirst	◯Yes ◯ No	Hypoglycemia	◯Yes ◯ No	Shingles	◯Yes ◯ No
Asthma	◯Yes ◯ No	Fainting / Dizziness	◯Yes ◯ No	Irregular Heartbeat	◯Yes ◯ No	Sickle Cell Disease	◯Yes ◯ No
Blood Disease	◯Yes ◯ No	Frequent Cough	◯Yes ◯ No	Jaundice	◯Yes ◯ No	Sinus Trouble	◯Yes ◯ No
Blood Transfusion	◯Yes ◯ No	Frequent Diarrhea	◯Yes ◯ No	Kidney Problems	◯Yes ◯ No	Spina Bifida	◯Yes ◯ No
Breathing Problem	◯Yes ◯ No	Frequent Headaches	◯Yes ◯ No	Leukemia	◯Yes ◯ No	Stomach / Intestinal Disease	◯Yes ◯ No
Bruise Easily	◯Yes ◯ No	Glaucoma	◯Yes ◯ No	Liver Disease	◯Yes ◯ No	Stroke	◯Yes ◯ No
Cancer	◯Yes ◯ No	Hay Fever / Allergies	◯Yes ◯ No	Low Blood Pressure	◯Yes ◯ No	Swelling of Limbs	◯Yes ◯ No
Chemotherapy	◯Yes ◯ No	Heart Attack	◯Yes ◯ No	Lung Disease	◯Yes ◯ No	Thyroid Disease	◯Yes ◯ No
Chest Pains	◯Yes ◯ No	Heart Failure (CHF)	◯Yes ◯ No	Mitral Valve Prolapse	◯Yes ◯ No	Tonsillitis	◯Yes ◯ No
Canker Sores	◯Yes ◯ No	Heart Murmur	◯Yes ◯ No	Osteoporosis	◯Yes ◯ No	Tuberculosis	◯Yes ◯ No
Cold Sores / Fever Blisters	◯Yes ◯ No	Heart Defibrillator	◯Yes ◯ No	Pain in Jaw / TMJ	◯Yes ◯ No	Tumors / Growths	◯Yes ◯ No
Congenital Heart Disorder	◯Yes ◯ No	Heart Pacemaker	◯Yes ◯ No	Parathyroid Disease	◯Yes ◯ No	Ulcers	◯Yes ◯ No

Have you ever had any serious illness not listed above? ◯Yes ◯ No ______________________

WOMEN: ARE YOU

Pregnant?	◯Yes ◯ No	Due Date?	____________
Taking Oral Contraceptives?	◯Yes ◯ No	Nursing?	◯Yes ◯ No

Question		
Are you under a physician's care now?	◯Yes ◯ No	If yes, please explain:________________
Have you been hospitalized or had a major operation?	◯Yes ◯ No	If yes, please explain:________________
Have you ever had a serious head or neck injury?	◯Yes ◯ No	If yes, please explain:________________
Are you taking any medications, vitamins, herbs or pills? *Including Non-Prescription or Over the Counter Medications*	◯Yes ◯No	***If yes, please fill out separate medication sheet***
Do you have a condition that requires antibiotic Premedication?	◯Yes ◯ No	If yes, please explain:________________
Do you take or have you taken Phen-Fen or Redux?	◯Yes ◯ No	
Have you ever taken Fosamax, Boniva, Actonel or other medications contaning bisphosphonates?	◯Yes ◯No	
Do you take any blood thinners or aspirin?	◯Yes ◯ No	
Are you on a special diet?	◯Yes ◯ No	If yes, please explain:________________
Do you use tobacco?	◯Yes ◯ No	
Do you use controlled substances?	◯Yes ◯ No	

Are you allergic to any of the following?

Allergen	
Aspirin	◯Yes ◯ No
Penicillin	◯Yes ◯ No
Sulfa Drugs	◯Yes ◯ No
Codeine	◯Yes ◯ No
Local Anesthetics	◯Yes ◯ No
Latex	◯Yes ◯ No
Metal	◯Yes ◯ No
Acrylic	◯Yes ◯ No
OTHER	◯Yes ◯ No

Primary Medical Doctor:

Name: ______________________

Address: ______________________

Phone #: ______________________

Do you play contact sports? ____________ ◯Yes ◯ No If yes, do you wear a mouth guard? ____________ ◯Yes ◯ No

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 this dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN ______________________ DATE: ____________