

Medical History

Although dental personnel primarily treat the area 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.

Name: _____ Phone: _____ Date of last medical exam: _____

What was the exam for? _____ Current Physician: _____

Y N
 Have you ever been hospitalized or had a major operation?
 Y N
 Are you under the care of a physician?
 Y N
 Have you ever had a serious head or neck injury?
 Y N
 Are you taking any medications or supplements?
 If yes please list, the dose and how often:
 (use back of paper if needed)

Y N
 Do you take or have you taken Phen-Fen or Redux?
 Y N
 Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
 Y N
 Are you on a special diet?
 Y N
 Do you use Tobacco?
 Y N
 Do you use controlled substances?

Women **Y** **N**
 Y N
 Are you pregnant or trying to get pregnant?
 Y N
 Are you taking contraceptives?
 Y N
 Are you nursing?

Are you allergic to any of the following?
 Aspirin
 Penicillin
 Local Anesthetics
 Acrylic
 Codeine
 Metal
 Latex
 Sulfa Drugs
 Other

CHECK ALL THAT APPLY:

FAMILY HISTORY UNKNOWN? YES NO

	HAVE	HAD	FAMILY HISTORY
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS\HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis\Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What Joint? _____			
When? _____			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type? _____			
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When? _____			
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores\Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	HAVE	HAD	FAMILY HISTORY
Epilepsy\Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells\Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack\Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble\Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type? _____			
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	HAVE	HAD	FAMILY HISTORY
Mitral Value Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When? _____			
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you wear a c-pap? Y <input type="checkbox"/> N <input type="checkbox"/>			
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach\Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? YES NO

If yes, please explain: _____

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: _____ Date: _____