Medical History Form

Although dental personnel primarily treat the area in and around the your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient's name (printed:_________________________

Patient's date of birth:_____________________________

❑ **There are no changes in my medical health history**

Patient signature/ Parent or Guardian Today's date

	Please circle	***If yes, please explain:***
Are you under a physician's care now? If yes, what is his/her name and phone number	Yes No	
Have you ever been hospitalized or had a major operation?	Yes No	
Have you had a serious head or neck injury?	Yes No	
Are you taking any medications, pills, or drugs?	Yes No	
Do you take or have you taken, Phen- Fen or Redux?	Yes No	
Have you ever taken Fosamax,Boniva,Actonel or any other medications containing bisphosphonates?	Yes No	
Do you use tobacco?	Yes No	
Do you need PreMedication prior to dental treatment?	Yes No	
Have you had a heart attack or stroke in the past year?	Yes No	
Do you have any artificial joints,prosthesis or history of infective endocarditis?	Yes No	
When was your last dental cleaning?		

<u>Are you allergic to any of the following?</u>

- ❑ Aspirin
- ❑ Metal
- ❑ Penicillin
- ❑ Latex
- ❑ Codeine
- ❑ Sulfa Drugs
- ❑ Acrylic
- ❑ Local Anesthetic

Check all that apply

- ❑ Do you use controlled substances?
- ❑ Are you interested on teeth whitening?
- ❑ Are interested in straightening your teeth?
- ❑ Are there any other dental concerns?

Do you have or have had any of the following?
Please check all that apply

- ❑ AIDS/HIV positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Cold Sores/ Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy/Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells or 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
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Rheumatic Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any other serious illness not listed above?______________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing false information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.