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

Are you under a phy	/sician's care now?	Yes 🔿 No If	yes, please explain:			
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:						
Have you ever had a serious head or neck injury? \bigcirc Yes \bigcirc No $_$ If yes, please explain:						
Are you taking any medications, pills, or drugs? 🚫 Yes 🚫 No If yes, please explain:						
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No						
Have you ever taken Fosamax. Boniva, Actonel or any and a second and						
other medications containing bisphosphonates? Ves Vo						
Are you on a special diet? \bigcirc Yes \bigcirc No						
Do you use tobacco? \bigcirc Yes \bigcirc No						
Do you use controlled substances? $\stackrel{\frown}{\bigcirc}$ Yes $\stackrel{\frown}{\bigcirc}$ No						
Women: Are you						
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No						
Are you allergic to any of the following?						
Aspirin Penicillin		ocal Anesthetics	Acrylic	Metal	Latex	Sulfa drugs
		ocal Allesthetics				
Other If yes, please explain:						
Do you have, or have you had, any of	0	○ Y== ○ N= ↓				
AIDS/HIV Positive Yes No Alzheimer's Disease Yes No	Cortisone Medicine Diabetes	○ Yes ○ No ○ Yes ○ No	Hemophilia () Hepatitis A)Yes () No)Yes () No	Radiation Treatments Recent Weight Loss	
Anaphylaxis	Drug Addiction		Hepatitis B or C) Yes \bigcirc No	Renal Dialysis	
Anemia	Easily Winded		Herpes	<u> </u>	Rheumatic Fever	
Angina (Yes No	Emphysema		High Blood Pressure	ĕ	Rheumatism	
Arthritis/Gout	Epilepsy or Seizures		High Cholesterol	Ŭ,	Scarlet Fever	
Artificial Heart Valve O Yes O No	Excessive Bleeding		Hives or Rash	ĕ	Shingles	
Artificial Joint	Excessive Thirst		Hypoglycemia	¥ I	Sickle Cell Disease	
Asthma O Yes O No	Fainting Spells/Dizzines	ğ ğ	Irregular Heartbeat	ĕ	Sinus Trouble	
Blood Disease	Frequent Cough		Kidney Problems	ĕ	Spina Bifida	
Blood Transfusion	Frequent Diarrhea		Leukemia	Yes () No	Stomach/Intestinal Disea	<u> </u>
Breathing Problem () Yes () No	Frequent Headaches		Liver Disease	ĕ	Stroke	
Bruise Easily (Ves (No	Genital Herpes		Low Blood Pressure	ě	Swelling of Limbs	
Cancer (Yes No	Glaucoma		Lung Disease	ý	Thyroid Disease	
Chemotherapy () Yes () No	Hay Fever		Mitral Valve Prolapse		Tonsillitis	◯ Yes ◯ No
Chest Pains	Heart Attack/Failure		Osteoporosis	ĕ	Tuberculosis	🔿 Yes 🔿 No
Cold Sores/Fever Blisters () Yes () No	Heart Murmur		Pain in Jaw Joints		Tumors or Growths	🔿 Yes 🔿 No
Congenital Heart Disorder Ves No	Heart Pacemaker		Parathyroid Disease	ĕ	Ulcers	🔵 Yes 🔵 No
Convulsions	Heart Trouble/Disease		Psychiatric Care	×	Venereal Disease	
		0 0 .			Yellow Jaundice	🔿 Yes 🔿 No
Have you ever had any serious illness not listed above? Yes No						
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.