

Medical History

Full Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 receive. Thank you for answering the follow questions.

- | | | | |
|---|---------------------------|--------------------------|-------------------------------|
| Are you under a physician's care now? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Are you taking any medications, pill, or drugs? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |
| Have you ever taken Fosamax, Boniva, Actonel, or any other
medications containing bisphosphonates? | <input type="radio"/> Yes | <input type="radio"/> No | _____ |
| Are you on a special diet? | <input type="radio"/> Yes | <input type="radio"/> No | |
| Do you use tobacco? | <input type="radio"/> Yes | <input type="radio"/> No | |
| Do you use controlled substances? | <input type="radio"/> Yes | <input type="radio"/> No | |

Women: Are you
 Pregnant/Trying to get pregnant? Nursing?
 Taking oral contraceptives?

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?**
- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Angina | <input type="checkbox"/> COVID-19/Coronavirus | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attach/Failure | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis/Bone Loss | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting | <input type="checkbox"/> Herpes | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Spells/Dizziness | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 the patient's) health. It is my responsibility to inform the dental office of my changes in medical status.

Signature of Patient, Parent, Or Guardian: _____ Date _____