

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

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 medications that you are taking could have an important interaction with the dentistry you will receive. Thank you for answering these questions:

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE NUMBER: _____

| | YES | NO | If yes, please explain: | MEDICATIONS: |
|---|--------------------------|--------------------------|--------------------------------|--------------|
| Are you under a physician's care now? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Have you ever had a serious head/neck injury? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Have you ever been on bisphosphonate therapy? (Fosamax, Actonel, Boniva, Didronel, Skelid) | <input type="checkbox"/> | <input type="checkbox"/> | If yes, for how long? _____ | _____ |

ALLERGIES: Are you allergic, or have you reacted adversely, to any of the following?

| | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Local anesthetic "Novocaine" | <input type="checkbox"/> Codeine, Demerol, other narcotic | <input type="checkbox"/> Latex or rubber dam | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Aspirin, Acetaminophen, Ibuprofen | <input type="checkbox"/> Reaction to metals | <input type="checkbox"/> Other: _____ |

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

| | YES | NO | | YES | NO | | YES | NO |
|-----------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| AIDS/HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer's Disease | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells /Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Anaphylaxis | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis/Gout | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Joint | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack / Failure | <input type="checkbox"/> | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pace Maker | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Breathing Problem | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Stomach / Intestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis: Type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Hives or Rash | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Sores/Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss, unexplained | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | | #per | Wk |
| Cortisone/Steroid Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | Do you use Tobacco? | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Do you use Alcohol? | | |
| Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Women : | YES | NO |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any serious disease, condition or problem not listed above? If yes, please explain: _____

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____

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