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

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

AIDS/HIV-Positive	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Angina	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Genital Herpes	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No			

Continued…			**If yes, please explain:**
Have you ever had any serious illness not listed on the previous page?	☐ Yes	☐ No	
Are you currently under the direct care of a physician?	☐ Yes	☐ No	
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	
Have you ever 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	
Are you on a special diet?	☐ Yes	☐ No	

Allergies Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics

☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other (please explain):

Lifestyle habits

☐ Do you use tobacco? ☐ Do you drink alcohol? ☐ Do you use controlled substances?

Women

☐ Are you using oral contraceptives? ☐ Are you pregnant or trying? ☐ Are you nursing?

Other information you would like us to know:

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.

Signed: _____ Date signed: _____

Patient, Parent or Guardian signature

Signed: _____ Date signed: _____

Doctor signature