

Medical History

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 physician's care now?	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
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No
Do you need to pre-medicate before a dental appointment?	Yes	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
Sulfa Drugs	Local Anesthetics	Red Dyes
Topical Anesthetic	Caffeine	NSAIDS (ibuprofen)
Other allergies		

Do you have, or have you had, any of the following?		
AIDS/HIV Positive	Cortisone Medicine	Hemophilia
Radiation Treatments	Alzheimer's Disease	Diabetes

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|---------------------------|----------------------------|--------------------|
| Hepatitis A | Recent Weight Loss | Anaphylaxis |
| Drug Addiction | Hepatitis B or C | Renal Dialysis |
| Anemia | Easily Winded | Herpes |
| Rheumatic Fever | Angina | Emphysema |
| High Blood Pressure | Rheumatism | Arthritis/Gout |
| Epilepsy or Seizures | High Cholesterol | Scarlet Fever |
| Artificial Heart Valve | Excessive Bleeding | Hives or Rash |
| Shingles | Artificial Joint | Excessive Thirst |
| Hypoglycemia | Sickle Cell Disease | Asthma |
| Fainting Spells/Dizziness | Irregular Heartbeat | Sinus Trouble |
| Blood Disease | Frequent Cough | Kidney Problems |
| Spina Bifida | Blood Transfusion | Frequent Diarrhea |
| Leukemia | Stomach/Intestinal Disease | Frequent Headaches |
| Liver Disease | Stroke | Bruise Easily |
| Genital Herpes | Low Blood Pressure | Swelling of Limbs |
| Cancer | Glaucoma | Lung Disease |
| Thyroid Disease | Chemotherapy | Hay Fever |
| Mitral Valve Prolapse | Tonsillitis | Chest Pains |
| Heart Attack/Failure | Osteoporosis | Tuberculosis |
| Cold Sores/Fever Blisters | Heart Murmur | Pain in Jaw Joints |
| Tumors or Growths | Congenital Heart Disorder | Heart Pacemaker |
| Parathyroid Disease | Ulcers | Convulsions |
| Heart Trouble/Disease | Yellow Jaundice | Psychiatric Care |
| Panic attacks | Venereal Disease | Heart Stents |
| Hearing Aids | Wheelchair | |

Have you ever had any serious illness not listed above? Yes No

This form was signed by:

- Patient
- Parent
- Spouse
- Guardian
- Other

First & Last Name

Email Address

Signature

x -----