Medical History

Patient Name: Birth Date: Date Created:

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.

Do you need to be Pre-Medicated prior to Dental Treatment?	Yes No	If yes	
Are you currently being treated for a medical condition?	Yes No	If yes	
Have you been hospitalized in the past 7 years?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Do you smoke or chew tobacco?	Yes No	If yes	
Do you use controlled substances?	Yes No	If yes	
Are you taking any medications, pills, or drugs? List:	Yes No	If yes	

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Do you have allergies to anything not listed above? Yes No If yes

Women are you . . .

Pregnant? Trying to get pregnant? Nursing?

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

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

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

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 my (or patient's) medical status.

Signature of Patient, Parent or Guardian:

X Date:_____