

MEDICAL HISTORY

Patient Name: _____

Birth date _____

Are you under a physician's care now? Yes No If yes, list all physicians that you see, their office phone numbers & what they are seen for:

Have you ever been hospitalized or had a major operation? Yes No If yes, list what & when: _____

Have you ever had a serious head or neck injury? Yes No If yes, list what & when: _____

Are you taking, or have you ever taken, Bisphosphonate drugs to strengthen bones? (Actonel, Aredia, Bonifos, Boniva, Didronel, Fosamax, Ostac, Skelid, Zometa, etc.)? If yes, what & how long: _____

List all other medications, pills or drugs & what they are taken for: _____

Do you take, or have you taken, Phen-Fen or Redux? If yes, what & how long? _____

If yes, have you had an ECHO Yes No Was it clear? Yes No

Do you use Tobacco? Yes No If yes, what & approx. how much daily? _____

Do you drink alcohol? Yes No If yes, how much daily? _____

Do you use controlled substances/recreational drugs? Yes No
If yes, what & for what reason? _____

Are you pregnant / trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you ALLERGIC to any of the following?

ASPIRIN PENICILLIN CODEINE ACRYLIC METAL LATEX LOCAL ANESTHETICS

List any other allergies or sensitivities: _____

Do you have any history of any of the following?

AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N	Cortisone Medicine	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Renal Dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N
Alzheimer's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N	Drug Addiction	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis B or C	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Easily Winded	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis/Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Hives or Rash	<input type="checkbox"/> Y <input type="checkbox"/> N	Sickle Cell Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypoglycemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Joint	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N	Irregular Heartbeat	<input type="checkbox"/> Y <input type="checkbox"/> N	Spina Bifida	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting Spells/Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Stomach/intestinal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Swelling of Limbs	<input type="checkbox"/> Y <input type="checkbox"/> N
Breathing Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Bruises Easily	<input type="checkbox"/> Y <input type="checkbox"/> N	Genital Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain in Jaw Joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumors or Growths	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest Pains	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack/Failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Parathyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Cold Sores/Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Congenital Heart Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Pace Maker	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N	Yellow Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N
Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Trouble/Diseas	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Alcoholism	<input type="checkbox"/> Y <input type="checkbox"/> N

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

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.

Signature: _____

Date _____

(parent or guardian to sign if patient is under 18 years of age)