Medical History:

PATIENT NAME _____ **BIRTH DATE**_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREATS THE AREA IN/AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR ANY SPECIFIC MEDICATION 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 THE CARE OF A PHYSICIAN CURRENTLY? _____
HAVE YOU BEEN HOSPITALIZED, AND/OR, HAD A MAJOR OPERATION? _____
-IF YES, PLEASE EXPLAIN _____
HAVE YOU EVER HAD A SERIOUS NECK/HEAD INJURY? _____
-IF YES, PLEASE EXPLAIN _____
ARE YOU CURRENTLY TAKING ANY MEDICATIONS, PILLS, OR DRUGS? _____

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

DO YOU TAKE, OR HAVE TAKEN, PHEN-FEN OR REDUX? _____
HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL, OR ANY MEDICATIONS CONTAINING BISPHOSPHONATES? _____
ARE YOU ON A SPECIAL DIET? _____
DO YOU USE TOBACCO? _____
DO YOU USE CONTROLLED SUBSTANCES? _____

WOMEN: ARE YOU.....
_____**PREGNANT/TRYING TO CONCIEVE?**
_____**NURSING?**
_____**TAKING ORAL CONTRACEPTIVES?**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

____ASPIRIN _____PENICILLIN _____CODEINE _____METAL _____LATEX _____LOCAL ANESTHETICS _____SULFA DRUGS
_____OTHER IF YES, PLEASE EXPLAIN _____

PLEASE MARK AN "X" TO ALL THAT MAY APPLY:

___AIDS/HIV POSITIVE
___ALZHEIMERS DISEASE
___ANAPHYLAXIS
___ANEMIA
___ANGINA
___ARTHRITIS/GOUT
___ARTIFICIAL HEART VALVE
___ARTIFICIAL JOINT
___ASTHMA
___BLOOD DISEASE
___BLOOD TRANSFUSION
___BREATHING PROBLEMS
___BRUISE EASILY
___CANCER
___CHEMOTHERAPY
___CHEST PAINS
___COLD SORES/FEVER BLISTERS
___CONGENITAL HEART DISORDER
___CONVULSIONS
___CORTISONE MEDICINE
___DIABETES
___DRUG ADDICTION
___EASILY WINDED
___EMPHYSEMA
___EPILEPSY/SEIZURES
___EXCESSIVE BLEEDING
___EXCESSIVE THIRST
___FAINTING SPELLS/DIZINESS
___FREQUENT COUGH
___FREQUENT DIARRHEA
___FREQUENT HEADACHES
___GENITAL HERPES
___GLAUCOMA
___HAY FEVER
___HEART ATTACK/FAILURE
___HEART MURMUR
___HEART PACEMAKER
___HEART TROUBLE/DISEASE
___HEMOPHILIA
___HEPATITIS A
___HEPATITIS B OR C
___HERPES
___HIGH BLOOD PRESSURE
___HIGH CHOLESTEROL
___HIVES OR RASH
___HYPOGYLCEMIA
___IRREGULAR HEARTBEAT
___KIDNEY PROBLEMS
___LEUKEMIA
___LIVER DISEASE
___LOW BLOOD PRESSURE
___LUNG DISEASE
___MITRAL VALVE PROLAPSE
___OSTEOPOROSIS
___PAIN IN JAW JOINTS
___PARATHYROID DISEASE
___PSYCHIATRIC CARE
___RADIATION TREATMENTS
___RECENT WEIGHT LOSS
___RENAL DIALYSIS
___RHEUMATIC FEVER
___RHEUMATISM
___SCARLET FEVER
___SHINGLES
___SICKLE CELL DISEASE
___SINUS TROUBLE
___SPINA BIFIDA
___STOMACH/INTESTIONAL DISEASE
___SLEEP APNEA
___STROKE
___SWELLING OF LIMBS
___THYROID DISEASE
___TONSILLITIS
___TUBERCULOSIS
___TUMORS/GROWTHS
___ULCERS
___VENERAL DISEASE
___YELLOW JAUNDICE

COMMENTS:
_____
_____
_____
_____
_____
_____

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 HAE BEEN ACURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENTS) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE:**_____