## **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 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 If yes, please explain:   |                                    |   |   |
|--|------------------------------------|---|---|
| Are you taking any medications, pills, or drugs? 🚫 Yes 🚫 No If yes, please explain:  |                                    |   |   |
| Do you take, or have you taken, Phen-Fen or Redux? () Yes () No  |                                    |   |   |
| Have you ever taken Fosamax. Boniva. Actonel or any and a second and |                                    |   |   |
| other medications containing bisphosphonates? Ves Vo   |                                    |   |   |
| Are you on a special diet? () Yes () No  |                                    |   |   |
| Do you use tobacco? $\bigcirc$ Yes $\bigcirc$ No   |                                    |   |   |
| Do you use controlled substances? $\bigcirc$ Yes $\bigcirc$ No   |                                    |   |   |
| ,  |                                    |   |   |
| Women: Are you Pregnant/Trying to get pregnant? () Yes () No Taking oral contraceptives? () Yes () No Nursing? () Yes () No  |                                    |   |   |
| Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No   |                                    |   |   |
| Are you allergic to any of the following?  |                                    |   |   |
| Aspirin Penicillin   | Codeine Local Anestheti            | ics Acrylic Metal                       | Latex Sulfa drugs                                     |
|  |                                    |   |   |
| Other If yes, please explain:  |                                    |   |   |
|  |                                    |   |   |
| Do you have, or have you had, any of   | •                                  |   |   |
| AIDS/HIV Positive O Yes O No   | Cortisone Medicine O Yes O No      |   | Radiation Treatments   Yes   No                       |
| Alzheimer's Disease O Yes O No   | Diabetes O Yes O No                |   | Recent Weight Loss Yes No                             |
| Anaphylaxis O Yes O No   | Drug Addiction Ores Oregonia       |   | Renal Dialysis () Yes () No                           |
| Anemia O Yes O No  | Easily Winded O Yes O No           |   | Rheumatic Fever OYes No                               |
| Angina O Yes O No  | Emphysema O Yes O N                | <b>3</b>                                | Rheumatism () Yes () No                               |
| Arthritis/Gout OYes No   | Epilepsy or Seizures () Yes () N   |   | Scarlet Fever OYes No                                 |
| Artificial Heart Valve O Yes O No  | Excessive Bleeding O Yes O N       |   | Shingles OYes No                                      |
| Artificial Joint O Yes O No  | Excessive Thirst O Yes O N         |   | Sickle Cell Disease Yes No                            |
| Asthma O Yes O No  | Fainting Spells/Dizziness Yes N    | <b>.</b>                                | Sinus Trouble O Yes O No                              |
| Blood Disease O Yes O No   | Frequent Cough OYes ON             | , , ,                                   | Spina Bifida () Yes () No                             |
| Blood Transfusion O Yes O No   | Frequent Diarrhea OYes ON          |   | Stomach/Intestinal Disease () Yes () No               |
| Breathing Problem O Yes O No   | Frequent Headaches O Yes O No      |   | Stroke OYes No  |
| Bruise Easily O Yes O No   | Genital Herpes O Yes O Ne          |   | Swelling of Limbs Ores No                             |
| Cancer O Yes O No  | Glaucoma O Yes O No                |   | Thyroid Disease Yes No                                |
| Chemotherapy Ores Orego No   | Hay Fever O Yes O No               |   | Tonsillitis () Yes () No<br>Tuberculosis () Yes () No |
| Chest Pains O Yes O No   | Heart Attack/Failure O Yes O No    |   | Tumors or Growths                                     |
| Cold Sores/Fever Blisters O Yes O No   | Heart Murmur O Yes O No            | <u> </u>                                |   |
| Congenital Heart Disorder Ves No   | Heart Pacemaker O Yes O No         | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Venereal Disease                                      |
| Convulsions () Yes () No   | Heart Trouble/Disease () Yes () No | o   Psychiatric Care () Yes () No       | Yellow Jaundice Yes No                                |
| Have you ever had any serious illness not listed above? O Yes O No   |                                    |   |   |
|  |                                    |   |   |
|  |                                    |   |   |
|  |                                    |   |   |
|  |                                    |   |   |
|  |                                    |   |   |
|  |                                    |   |   |
|  |                                    |   |   |
|  |                                    |   |   |

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.