Medical History (Use this one)

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, c important interrelationship with the dentistry you will receive. Check "No" if the condition/question does not apply to you - NO BLANK FIELDS PLEASE. Thank you for answering the following quest

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco or controlled substances?	Yes No	
Are you taking any medications, pills, or drugs?	Yes No	If yes

Are you allergic to any of the following?

No Known Medical Allergies	Yes No	Codeine	Yes No	Latex	Yes No
Metal	Yes No	Acrylic	Yes No	Local Anesthetics	Yes No
Penicillin	Yes No	Sulfa Drugs	Yes No	Sulfites	Yes No

Other? Yes No If yes

Have you taken...

Fosamax, Boniva, Actonel, or other bisphosphonates	Yes No	Any steroid (like cortisone) for more than 2 weeks	Yes No

Women: are you...

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

Please answer the following...

I snore or have been told that I snore	Yes No	I am overly tired during the day	Yes No	I have been told that I stop breathing/h	Yes No	I know or have been told that I grind my	Yes No

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

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

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

Comments:

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 of Patient, Parent or Guardian:

X Date:_____