Medical History Form

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 following questions.

Are you under a physician's care now? *
◯ Yes ◯ No

If "Yes" Please Describe *

Have you ever been hospitalized or had a major operation? *
◯ Yes ◯ No

If "Yes" Please Describe *

Have you ever had a serious head or neck injury? *
◯ Yes ◯ No

If "Yes" Please Describe *

Are you taking any medications, pills, or drugs? *
◯ Yes ◯ No

If "Yes" Please Describe *

Do you take, or have you taken, Phen-fen or Redux? *
◯ Yes ◯ No

If "Yes" Please Describe *

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? *
◯ Yes ◯ No

If "Yes" Please Describe *

Are you on a special diet? *
◯ Yes ◯ No

Do you use tobacco? *
◯ Yes ◯ No

Do you use controlled substances? *
◯ Yes ◯ No

If "Yes" Please Describe *

Women: Are you...

☐ Pregnant / Trying to get pregnant?
☐ Taking oral contraceptives?
☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin
☐ Acrylic
☐ Sulfa Drugs
☐ Penicillin
☐ Metal
☐ Local Anesthetics
☐ Codeine
☐ Latex
☐ Other

If "Other" Please Describe *

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

AIDS / HIV Positive * ◯ Yes ◯ No

Alzheimer's Disease * ◯ Yes ◯ No

Anaphylaxis * ◯ Yes ◯ No

Anemia * ◯ Yes ◯ No

Angina * ◯ Yes ◯ No

Arthritis / Gout * ◯ Yes ◯ No

Artificial Heart Valve * ◯ Yes ◯ No

Artificial Joint * ◯ Yes ◯ No

Asthma * ◯ Yes ◯ No

Blood Disease * ◯ Yes ◯ No

Blood Transfusion * ◯ Yes ◯ No

Breathing Problems * ◯ Yes ◯ No

Bruise Easily * ◯ Yes ◯ No

Cancer * ◯ Yes ◯ No

Chemotherapy * ◯ Yes ◯ No

Chest Pains * ◯ Yes ◯ No

Cold Sores / Fever Blisters * ◯ Yes ◯ No

Congenital Heart Disorder * ◯ Yes ◯ No

Convulsions * ◯ Yes ◯ No

Cortisone Medicine * ◯ Yes ◯ No

Diabetes * ◯ Yes ◯ No

Drug Addiction * ◯ Yes ◯ No

Easily Winded * ◯ Yes ◯ No

Emphysema * ◯ Yes ◯ No

Epilepsy or Seizures * ◯ Yes ◯ No

Excessive Bleeding * ◯ Yes ◯ No

Excessive Thirst * ◯ Yes ◯ No

Fainting Spells / Dizziness * ◯ Yes ◯ No

Frequent Cough * ◯ Yes ◯ No

Frequent Diarrhea * ◯ Yes ◯ No

Frequent Headaches * ◯ Yes ◯ No

Genital Herpes * ◯ Yes ◯ No

Glaucoma * ◯ Yes ◯ No

Hay Fever * ◯ Yes ◯ No

Heart Attack / Failure * ◯ Yes ◯ No

Heart Murmur * ◯ Yes ◯ No

Heart Pacemaker * ◯ Yes ◯ No

Heart Trouble / Disease * ◯ Yes ◯ No

Hemophilia * ◯ Yes ◯ No

Hepatitis A * ◯ Yes ◯ No

Hepatitis B or C * ◯ Yes ◯ No

Herpes * ◯ Yes ◯ No

High Blood Pressure * ◯ Yes ◯ No

High Cholesterol * ◯ Yes ◯ No

Hives or Rash * ◯ Yes ◯ No

Hypoglycemia * ◯ Yes ◯ No

Irregular Heartbeat * ◯ Yes ◯ No

Kidney Problems * ◯ Yes ◯ No

Leukemia * ◯ Yes ◯ No

Liver Disease * ◯ Yes ◯ No

Low Blood Pressure * ◯ Yes ◯ No

Lung Disease * ◯ Yes ◯ No

Mitral Valve Prolapse * ◯ Yes ◯ No

Osteoporosis * ◯ Yes ◯ No

Pain in Jaw Joint * ◯ Yes ◯ No

Parathyroid Disease * ◯ Yes ◯ No

Psychiatric Care * ◯ Yes ◯ No

Radiation Treatments * ◯ Yes ◯ No

Recent Weight Loss * ◯ Yes ◯ No

Renal Dialysis * ◯ Yes ◯ No

Rheumatic Fever * ◯ Yes ◯ No

Rheumatism * ◯ Yes ◯ No

Scarlet Fever * ◯ Yes ◯ No

Shingles * ◯ Yes ◯ No

Sickie Cell Disease * ◯ Yes ◯ No

Sinus Trouble * ◯ Yes ◯ No

Spina Bifida * ◯ Yes ◯ No

Stomach / Intestinal Disease * ◯ Yes ◯ No

Stroke * ◯ Yes ◯ No

Swelling of Limbs * ◯ Yes ◯ No

Thyroid Disease * ◯ Yes ◯ No

Tonsillitis * ◯ Yes ◯ No

Tuberculosis * ◯ Yes ◯ No

Tumors or Growths * ◯ Yes ◯ No

Ulcers * ◯ Yes ◯ No

Venereal Disease * ◯ Yes ◯ No

Yellow Jaundice * ◯ Yes ◯ No

Have you ever had any serious illness not listed above? * ◯ Yes ◯ No

If "Yes" Please List *

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.

Name of Patient, Parent or Guardian *

First Name Last Name

Date *

Month Day Year

Signature