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.

Have you ever been hospitalized or had a major operation? Yes No Have you ever had a serious head or neck injury? Yes No Are you taking any medications, pills, or drugs? Yes No Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax. Boniva, Actonel or any	If yes, please explain:	
other medications containing bisphosphonates? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Women: Are you Yes No Pregnant/Trying to get pregnant? Yes No No Nursing? Yes No		
Are you allergic to any of the following? Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetic Other If yes, please explain:	s 🗌 Acrylic 🗌 Metal	Latex Sulfa drugs
Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis 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 Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Bruise Easily Yes No Chemotherapy Yes No Chemotherapy Yes No Chemotherapy Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Heart Murmur Yes </td <td>Hemophilia Yes No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure 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 Low Blood Pressure Yes No Lung Disease Yes No Mitral Valve Prolapse Yes No Osteoporosis Yes No Parathyroid Disease Yes No Psychiatric Care Yes No</td> <td>Radiation Treatments Yes No Recent Weight Loss Yes No Renal Dialysis Yes No Rheumatic Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Shingles Yes No Sickle Cell Disease Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tuberculosis Yes No Tumors or Growths Yes No Venereal Disease Yes No Yellow Jaundice Yes No</td>	Hemophilia Yes No Hepatitis A Yes No Hepatitis B or C Yes No Herpes Yes No High Blood Pressure 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 Low Blood Pressure Yes No Lung Disease Yes No Mitral Valve Prolapse Yes No Osteoporosis 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 Scarlet Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Shingles Yes No Sickle Cell Disease Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Swelling of Limbs Yes No Thyroid Disease Yes No Tuberculosis Yes No Tumors or Growths Yes No Venereal Disease Yes No Yellow Jaundice Yes 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.