## **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 phy	/sician's care now? () Yes (	⊖ No lf v	ves, please explain:			
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:						
Have you ever had a serious head or neck injury? () 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 Vac Ala						
other medications containing bisphosphonates? Yes No						
Are you on a special diet? O Yes O No						
Do you use tobacco? () Yes () No						
Do you use controlled substances? O Yes O 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 Ar	nesthetics	Acrylic	Metal	Latex	Sulfa drugs
						Ū
Other If yes, please explain:						
Do you have, or have you had, any of the following?						
	-	es () No			Dediction Transferents	
AIDS/HIV Positive () Yes () No Alzheimer's Disease () Yes () No	ĕ		Hemophilia () Hepatitis A	Yes () No Yes () No	Radiation Treatments Recent Weight Loss	
Anaphylaxis () Yes () No	ě		Hepatitis B or C	ĕ	Recent Weight Loss Renal Dialysis	○ Yes ○ No ○ Yes ○ No
Anemia	° č		Herpes	×	Rheumatic Fever	
Angina	, .		High Blood Pressure	×	Rheumatism	
Arthritis/Gout			High Cholesterol	× I	Scarlet Fever	
Artificial Heart Valve		es () No	v ý	Yes () No	Shingles	
Artificial Joint	° ĕ		Hypoglycemia	×	Sickle Cell Disease	
Asthma	Fainting Spells/Dizziness Ye	Ý	Irregular Heartbeat	ĕ	Sinus Trouble	
Blood Disease			Kidney Problems	×	Spina Bifida	
Blood Transfusion			Leukemia	ĕ	Stomach/Intestinal Disease	y y
			Liver Disease		Stroke	
	, č		ĕ	<u> </u>	Swelling of Limbs	
Bruise Easily () Yes () No Cancer () Yes () No					Thyroid Disease	
Chemotherapy () Yes () No	ĕ		Lung Disease	ă	Tonsillitis	
Chest Pains	, 9		Osteoporosis	ā	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters () Yes () No			Pain in Jaw Joints	ĕ	Tumors or Growths	Ŏ Yes Ŏ No
Congenital Heart Disorder Ves No	ğ		Parathyroid Disease	ă	Ulcers	🔿 Yes 🔿 No
Convulsions	ě		Psychiatric Care	ă	Venereal Disease	
Yellow Jaundice Yes (No						
Have you ever had any serious illness not listed above? Yes No						
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.