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: _____
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 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	_____
Do you need a Premed before dental appointments?	○ Yes ○ No	_____
Do you use any devices to sleep?	○ Yes ○ No	_____

Women: Are you
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 Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other If yes, please explain: _____

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

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

Have you had any past ortho/braces/aligners?	○ Yes ○ No	If yes, explain: _____
Have you had any wisdom teeth removed?	○ Yes ○ No	If yes, explain: _____
Do you have any loose, sweet, sensitive, hot or cold sensitive teeth?	○ Yes ○ No	If yes, explain: _____
Do you have bad breath or taste that won't go away?	○ Yes ○ No	If yes, explain: _____
Do you have pain when chewing?	○ Yes ○ No	If yes, explain: _____
Do you have red, swollen or tender gums?	○ Yes ○ No	If yes, explain: _____
Have you ever been told you have periodontal disease?	○ Yes ○ No	If yes, explain: _____
Have you had any past bad dental experiences?	○ Yes ○ No	If yes, explain: _____
Have you ever had any dental trauma?	○ Yes ○ No	If yes, explain: _____
Are you happy with your smile/teeth?	○ Yes ○ No	If yes, explain: _____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____