Patient Medical History

Patient Name: _____ DOB: _____

Although dental personal primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, pre medication that you may be taking, could have an important relationship 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: _____

Have you ever been hospitalized/ Had a major operation? ○ Yes ○ No If yes: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes: _____

Are you taking any medications? ○ Yes ○ No If yes: _____

Do you, or have you, take Phen-Fen or Redox? ○ Yes ○ No If yes: _____

Have you ever take a Bisphosphonate? (Including Fosamax, Boniva, Acronel) ○ Yes ○ No If yes: _____

Are you on a special diet? ○ Yes ○ No **Do you use tobacco?** ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No If yes: _____

Women: Are you...

☐ Pregnant/Trying to conceive? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

☐ Other? Please list: _____ ☐ NKDA

Do you have, or have ever had, any of the following? (please mark all that apply)

Aids/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatment	○ Yes ○ No
Alzheimer's disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A,B, or C	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Herpes	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Hives/Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting/Dizzy Spells	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spine Bifida	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach Disease	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Cold Sores	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Pain In Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Ulcers	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No		
Heart Pacemaker	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No		
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○		
Congenital Heart Disorder	○ Yes ○ No			MitralValve Prolapsed	○ Yes ○ No		

Have you ever had any serious illness not listed above? _____

Comments: _____

_____

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

Patient/Guardian Signature: _____ Date: _____