

Medical History Form

Patient Name:

Birth Date:

Date Created:

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.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or 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, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

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

Are you on a special diet? Yes No If yes

Do you use smoke or use E-cigarettes? How much per day and for how many years? Yes No If yes

Do you chew tobacco? How much per day and for how many years? Yes No If yes

Do you use controlled substances? Yes No If yes

Women: Are you...

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

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics
 Clindamycin

Do you have any other allergies? Please describe. Yes No If yes

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

<input type="checkbox"/> Acid Reflux/Heartburn/GERD	<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Shingles
<input type="checkbox"/> Angina/Chest Pains	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Human Papilloma Virus (HPV)	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sleep Apnea/Sleep Disorders
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Blood Thinning Medication	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tonsils/Adenoids Removed
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Radiation Treatments	

Have you ever had any serious illness not listed Yes No If yes

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.

Signature of Patient, Parent or Guardian:

X

Date: _____