

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 impact on 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: \_\_\_\_\_
- Do you currently use or have you used a Hard Night Guard? Yes  No  If yes, please explain: \_\_\_\_\_
- Are you on a special diet? Yes  No  If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, bisphosphonate such as Fosamax, Boniva, Zometa or Actonel? Yes  No  If yes, please explain: \_\_\_\_\_
- Do you currently use, or have you used tobacco in the past? Yes  No  If yes, please explain: \_\_\_\_\_
- Do you currently use or have you used drugs in the past? Yes  No  If yes, please explain: \_\_\_\_\_

**List any medications or supplements you are currently taking:**

<u>Name of Medication</u>	<u>Dosage</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_
- If yes, please explain \_\_\_\_\_

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

Acid Reflux	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cortisone Medicine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>
AIDS/HIV Positive	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Pace Maker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alzheimer's Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug Addiction	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemophilia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anaphylaxis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis A, B or C	Yes <input type="checkbox"/> No <input type="checkbox"/>	Renal Dialysis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Endocarditis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis/Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy/Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sickle Cell Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valve	Yes <input type="checkbox"/> No <input type="checkbox"/>	Excessive Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hypoglycemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joint	Yes <input type="checkbox"/> No <input type="checkbox"/>	Excessive Thirst	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting/Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Leukemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Pains	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lung Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Clench or Grind Teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumors	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cold Sores	Yes <input type="checkbox"/> No <input type="checkbox"/>	Irregular Heartbeat	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pain in Jaw Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Colitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Parathyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Have you ever had any serious illness not listed above? Yes  No  If yes, please explain: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_