# 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: _____

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

If yes, please explain: _____

**Are you on a special diet?** Yes ☐ No ☐ **Do you use tobacco?** Yes ☐ No ☐ **Do you use any controlled substances?** Yes ☐ No ☐

If yes, please explain: _____

**Sex:** Male ☐ Female ☐ **Women are you:** Pregnant/Trying to get pregnant? Yes ☐ No ☐ Taking oral contraseptive? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

**Are you allergic to any of the following?** ☐ Aspirin ☐ Metal ☐ Penicillin ☐ Latex ☐ Codeine ☐ Sulfa drugs ☐ Acrylic ☐ Local Anesthetics

Other ☐ If yes, please explain: _____

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

| | | | |
|---|---|---|---|
| Artificial Heart Valve Yes ☐ No ☐ | Hives or Rash Yes ☐ No ☐ | Alzheimer's Disease Yes ☐ No ☐ | Recent Weight Loss (Gain) Yes ☐ No ☐ |
| Chest Pains Yes ☐ No ☐ | Lung Disease Yes ☐ No ☐ | Epilepsy or Seizures Yes ☐ No ☐ | Swelling of Limbs Yes ☐ No ☐ |
| Congenital Heart Disorder Yes ☐ No ☐ | Sinus Trouble Yes ☐ No ☐ | Fainting Spells/Dizziness Yes ☐ No ☐ | Arthritis/Gout Yes ☐ No ☐ |
| Heart Attack/Failure Yes ☐ No ☐ | Tuberculosis Yes ☐ No ☐ | Frequent Headaches Yes ☐ No ☐ | Rheumatoid Arthritis Yes ☐ No ☐ |
| Heart Murmur Yes ☐ No ☐ | Cancer Yes ☐ No ☐ | Migraines Yes ☐ No ☐ | Artificial Joint Yes ☐ No ☐ |
| Heart Pacemaker Yes ☐ No ☐ | Chemotherapy Yes ☐ No ☐ | Psychiatric Care Yes ☐ No ☐ | Autoimmune Disease Yes ☐ No ☐ |
| Heart Trouble/Disease Yes ☐ No ☐ | Diabetes Yes ☐ No ☐ | Stroke/TIA Yes ☐ No ☐ | Glaucoma Yes ☐ No ☐ |
| High Blood Pressure Yes ☐ No ☐ | Pre-Diabetic Yes ☐ No ☐ | AIDS/HIV Positive Yes ☐ No ☐ | Obstructive Seep Apnea Yes ☐ No ☐ |
| Irregular Heartbeat Yes ☐ No ☐ | Hypoglycemia Yes ☐ No ☐ | Bruise Easily Yes ☐ No ☐ | Osteoporosis Yes ☐ No ☐ |
| Low Blood Pressure Yes ☐ No ☐ | High Cholesterol Yes ☐ No ☐ | Hemophilia Yes ☐ No ☐ | Pain Jaw Joints/TMJ Yes ☐ No ☐ |
| Mitral Valve/Prolapse Yes ☐ No ☐ | Kidney Problems Yes ☐ No ☐ | Hepatitis B or C Yes ☐ No ☐ | Parathyroid Disease Yes ☐ No ☐ |
| Anaphylaxis Yes ☐ No ☐ | Renal Dialysis Yes ☐ No ☐ | STD Disease Yes ☐ No ☐ | Thyroid Disease Yes ☐ No ☐ |
| Breathing Problem Yes ☐ No ☐ | Leukemia Yes ☐ No ☐ | Cold Sores/Fever Blisters Yes ☐ No ☐ | Tonsillitis Yes ☐ No ☐ |
| COPD Yes ☐ No ☐ | Liver Disease Yes ☐ No ☐ | Herpes Yes ☐ No ☐ | OTHER Yes ☐ No ☐ |
| Frequent Cough Yes ☐ No ☐ | Stomach/Intestinal Disease Yes ☐ No ☐ | Shingles Yes ☐ No ☐ | |
| Hay Fever Yes ☐ No ☐ | Ulcers Yes ☐ No ☐ | Drug Addiction Yes ☐ No ☐ | |
| | | Tumors or Growths 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.

Signature: _____ Date: _____