Medical History

Today's Date _____
Patient Name_____ Birth Date_____
Home telephone#_____Work #_____Cell # _____
Emergency Contact person _____Telephone # _____
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? (Being treated for anything right now, not regular check-ups.)
____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 _____
Are you on a special diet? ___ Yes ____No
Do you use tobacco? _____Yes _____No

FOR WOMEN ONLY
_____Pregnant/Trying to get pregnant
_____Taking Oral Contraceptives?

Are you allergic to any of the following?
____Aspirin ____Penicillin ____Codeine ____Acrylic ____Metal ____Latex ____Local Anesthetics
____Sulfa Drugs ____Other, if yes please explain:_____

Do you have, or have you had, any of the following? - please circle.

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
ANYTHING Artificial
Asthma
Blood Transfusion
Breathing Problem
Bruise Easily
Fainting Spells/Dizziness
Frequent Cough
Frequent Headaches
Irregular Heartbeat
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Pain in Jaw Joints
Radiation Treatments
Renal Dialysis
Rheumatic Fever
Scarlet Fever
Shingles
Sinus Trouble
Spinal Bifida
Stent - if so - where
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease

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Do you have, or have you had, any of the following? - please circle

Cancer	Hepatitis B or C	
Chemotherapy	High Blood Pressure	Tuberculosis
Convulsions	High Cholesterol	Tumors or Growths
Chest Pains	Hives or Rash	Ulcers
Cold Sores/Fever Blisters	Hypoglycemia	Yellow Jaundice
Congenital Heart Disorder	Kidney Problems	
Diabetes	Leukemia	
Drug Addiction	Liver Disease	
Easily Winded	Low Blood Pressure	
Emphysema	Lung Disease	
Epilepsy or Seizures	Mitral Valve Prolapse	
Excessive Bleeding	MRSA	
Excessive Thirst	Osteoporosis	

Have you ever had any serious illness not listed above? ____Yes _____NO If yes, please explain:
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 _____
DATE _____

IF YOU HAVE AN EMAIL ADDRESS;
We would like to start emailing you to remind you of your cleaning appointment, if that is ok, please give us your email address. Thanks. _____.