

MEDICAL HISTORY

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 take, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under a physician's care? Yes No If yes, please explain _____

Have you 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 medication, pills, or drugs? Yes No If yes, please explain _____

Do you take, have haven taken Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No Women: Are you
 Pregnant/Trying to get pregnant? Nursing?

Do you use controlled substances? Yes No Taking oral contraception?

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?

- | | | | |
|---|---|---|--|
| <input type="radio"/> Aids/HIV Positive | <input type="radio"/> Cortisone Medicine | <input type="radio"/> High Blood Pressure | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Alzheimer's disease | <input type="radio"/> Diabetes | <input type="radio"/> Hypoglycemia | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Drug Addiction | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Stroke |
| <input type="radio"/> Anemia | <input type="radio"/> Emphysema | <input type="radio"/> Kidney Problems | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Angina | <input type="radio"/> Epilepsy/seizures | <input type="radio"/> Leukemia | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Liver Disease | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Excessive Thirst | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Lung Disease | <input type="radio"/> Tumors of Growths |
| <input type="radio"/> Asthma | <input type="radio"/> Frequent Cough | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Ulcers |
| <input type="radio"/> Blood Disease | <input type="radio"/> Frequent Headaches | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Glaucoma | <input type="radio"/> Parathyroid Disease | |
| <input type="radio"/> Breathing problems | <input type="radio"/> Hay Fever | <input type="radio"/> Psychiatric Care | |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Heart Attack/ Failure | <input type="radio"/> Radiation Treatments | |
| <input type="radio"/> Cancer | <input type="radio"/> Heart Murmur | <input type="radio"/> Recent weight loss | |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hepatitis A | <input type="radio"/> Renal Dialysis | |
| <input type="radio"/> Chest Pains | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Rheumatic Fever | |
| <input type="radio"/> Cold sores/Fever Blisters | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Rheumatism | |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Sickle Cell Disease | |
| <input type="radio"/> Convulsions | <input type="radio"/> Hemophilia | <input type="radio"/> Sinus Trouble | |

Have you ever taken Fosamax, Actonel, Boniva or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any other drugs for metastasis bone cancer?

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