Medical History

Name _____ Birthdate _____

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
Physician's name: _____
Phone number: ( ) _____
Do you take or have you recently taken any prescription? ○Yes ○No
If yes, list here: _____
_____
_____

Do you take or have you taken Phen-Fen or Redux? ○Yes ○No
Are you currently taking or are you scheduled to begin taking either alendronate (Fosamax) or risedronate (Actonel) for either osteoperosis or Paget's disease? ○Yes ○No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biophosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ○Yes ○No
Date that said treatment began: _____

Have you ever had a serious head or neck injury? ○Yes ○No
Have you had a serious illness, operation or been hospitalized any time in the past 5 years? ○Yes ○No
If yes, explain: _____
_____

Do you currently have earaches or neck pain? ○Yes ○No
Do you have clicking, popping, or jaw discomfort? ○Yes ○No
Do you have sores or ulcers in your mouth? ○Yes ○No
Have you ever had a serious injury in your mouth? ○Yes ○No
Do you use controlled substances or illegal drugs? ○Yes ○No
Do you use tobacco (cigarettes, snuff, chew, bidis)? ○Yes ○No
Are you interested in stopping? ○Yes ○No
Do you drink alcoholic beverages? ○Yes ○No
If yes, how much did you drink in the last 24 hours? _____
If yes, how much do you typically drink in a week? _____
Women only: Are you pregnant? ○Yes ○No # of Weeks: _____
Taking birth control pills or hormonal replacement? ○Yes ○No
Are you nursing? ○Yes ○No

Allergies - Are you allergic to or have you had a reaction to any of the following:

Local Anesthetics ○Yes ○No	Animals ○Yes ○No	Iodine ○Yes ○No	Sulfa Drugs ○Yes ○No
Aspirin ○Yes ○No	Metals ○Yes ○No	Codeine ○Yes ○No	Food ○Yes ○No
Penicillin ○Yes ○No	Latex (Rubber) ○Yes ○No	Sleeping Pills ○Yes ○No	Other ○Yes ○No

Other: _____

Do you have or have you ever had any of the following:

Heart Murmur ○Yes ○No Mitral Valve Prolapse ○Yes ○No Artificial Heart Valves ○Yes ○No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

If yes, when (date): _____ Physician's Name: _____

Aids/HIV Positive	○Yes	○No	Coronary Artery Disease	○Yes	○No	Headaches/Migranes	○Yes	○No	Low Blood Pressure	○Yes	○No
Alzheimer's Disease	○Yes	○No	Damaged Heart Valves	○Yes	○No	Heart Attack/Failure	○Yes	○No	Lung Disease	○Yes	○No
Abnormal Bleeding	○Yes	○No	Diabetes	○Yes	○No	Heartburn	○Yes	○No	Malnutrition	○Yes	○No
Anaphylaxis	○Yes	○No	Drug Addiction	○Yes	○No	Heart Pace Maker	○Yes	○No	Mental Health Disorders	○Yes	○No
Anemia	○Yes	○No	Easily Winded	○Yes	○No	Heart Trouble/Disease	○Yes	○No	Neurological Disorders	○Yes	○No
Angina	○Yes	○No	Eating Disorder	○Yes	○No	Hemophillia	○Yes	○No	Osteoperosis	○Yes	○No
Arthritis/Gout	○Yes	○No	Emphysema	○Yes	○No	Hepatitis A	○Yes	○No	Pace Maker	○Yes	○No
Artificial Joint(s)	○Yes	○No	Epilepsy or Seizures	○Yes	○No	Hepatitis B & C	○Yes	○No	Radiation Treatment	○Yes	○No
Asthma	○Yes	○No	Excessive Bleeding	○Yes	○No	Herpes	○Yes	○No	Recurrent Infections	○Yes	○No
Autoimmune Disease	○Yes	○No	Excessive Thirst	○Yes	○No	High Blood Pressure	○Yes	○No	Rheumatoid Arthritis	○Yes	○No
Blood Transfusion	○Yes	○No	Excessive Urination	○Yes	○No	Hives or Rash	○Yes	○No	Scarlet Fever	○Yes	○No
Blood Disease	○Yes	○No	Fainting/Dizziness	○Yes	○No	Hypoglycemia	○Yes	○No	Shingles	○Yes	○No
Bruise Easily	○Yes	○No	Frequent Cough	○Yes	○No	Irregular Heart Beat	○Yes	○No	Sinus Trouble	○Yes	○No
Cancer	○Yes	○No	Gastrointestinal Disease	○Yes	○No	Kidney Problems	○Yes	○No	Tonsillitis	○Yes	○No
Cardivascular Disease	○Yes	○No	Glaucoma	○Yes	○No	Lukemia	○Yes	○No	Tuberculosis	○Yes	○No
Congenital Heart Disorder	○Yes	○No	Hay Fever	○Yes	○No	Liver Disease	○Yes	○No	Ulcers	○Yes	○No
Convulsions	○Yes	○No	Comments: _____								

_____
_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature (Patient, Parent or Guardian): _____ Date: _____
Signature (Patient, Parent or Guardian): _____ Date: _____
Signature (Patient, Parent or Guardian): _____ Date: _____