Medical History

Patient Name: Birth date:

Are you under a physician’s care now? Yes No If yes, name

Have you ever been hospitalized or had a major operation? Yes No

If yes, what/when?

Have you ever had a serious head or neck injury: Yes No

If yes, what/when?

Are you taking any medications, pills, or drugs? Yes No

If yes, what?

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, when?

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

Women: are you …

Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other:

Do you use controlled substances? Yes No If yes,

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

AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No

Alzheimer’s Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No

Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes No

Anemia Yes No Easily Winded Yes No Herpes Yes No Rheumatic Fever Yes No

Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatism Yes No

Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No

Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes No

Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No

Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No

Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No

Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No

Breathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes No

Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No

Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No

Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes No

Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes No

Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumor or Growths Yes No

Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Ulcers Yes No

Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes No

Yellow Jaundice Yes No

Have you ever had any serious illness not listed? Yes No If yes,

Current medical provider:

Current medical clinic:

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.

X Date:

Signature of patient or guardian