

## Medical History

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. The following questions will insure that we provide you with accurate care during your visit.**

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-fen or Redux? Are you on a special diet? Do you use tobacco? Do you use controlled substances? Have you ever taken Fosamax/Bisphosphonates Do you consider yourself a nervous patient? Have you ever used N2O or a sedative during Treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No No No No No No No No No No No No No	If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____ If yes, Please explain: _____
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Comments: \_\_\_\_\_

### Women are you?

- Pregnant or Trying to Conceive
- Taking Contraceptives?
- Nursing
- Taking Estrogen Therapy?

### Are you allergic to any of the following?

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Aspirin</li> <li><input type="checkbox"/> Latex</li> <li><input type="checkbox"/> Iodine</li> <li><input type="checkbox"/> Acrylic</li> <li><input type="checkbox"/> Penicillin/ antibiotics</li> <li><input type="checkbox"/> Other</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Codeine</li> <li><input type="checkbox"/> Sedatives</li> <li><input type="checkbox"/> Sulfur</li> <li><input type="checkbox"/> Metal</li> <li><input type="checkbox"/> Local Anesthetics</li> </ul> |
|---|---|

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

- |  |  |  |  |
|--|--|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> AIDS/HIV</li> <li><input type="checkbox"/> Alzheimer's</li> <li><input type="checkbox"/> Anaphylaxis</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Angina</li> <li><input type="checkbox"/> Arthritis/Gout</li> <li><input type="checkbox"/> Artificial Heart Valve</li> <li><input type="checkbox"/> Artificial Joint</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Blood Disease</li> <li><input type="checkbox"/> Blood Transfusion</li> <li><input type="checkbox"/> Breathing Problem</li> <li><input type="checkbox"/> Bruise Easily</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Chemotherapy</li> <li><input type="checkbox"/> Chest Pains</li> <li><input type="checkbox"/> Cold Sores/Fever Blisters</li> <li><input type="checkbox"/> Congenital Heart Disorder</li> <li><input type="checkbox"/> Convulsions</li> <li><input type="checkbox"/> Cortisone Medicine</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Drug Addiction</li> <li><input type="checkbox"/> Easily Winded</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Epilepsy/Seizures</li> <li><input type="checkbox"/> Excessive Bleeding</li> <li><input type="checkbox"/> Excessive Thirst</li> <li><input type="checkbox"/> Fainting Spells/Dizziness</li> <li><input type="checkbox"/> Frequent Cough</li> <li><input type="checkbox"/> Frequent Diarrhea</li> <li><input type="checkbox"/> Frequent Headaches</li> <li><input type="checkbox"/> Genital Herpes</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Hay Fever</li> <li><input type="checkbox"/> Heart Attack/Failure</li> <li><input type="checkbox"/> Heart Murmur</li> <li><input type="checkbox"/> Heart Pace Maker</li> <li><input type="checkbox"/> Heart Trouble/Disease</li> <li><input type="checkbox"/> Hemophilia</li> <li><input type="checkbox"/> Hepatitis A</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Hepatitis B or C</li> <li><input type="checkbox"/> Herpes</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Hives or Rash</li> <li><input type="checkbox"/> Hypoglycemia</li> <li><input type="checkbox"/> Immune Disorders</li> <li><input type="checkbox"/> Irregular Heart Beat</li> <li><input type="checkbox"/> Kidney Problems</li> <li><input type="checkbox"/> Leukemia</li> <li><input type="checkbox"/> Liver Disease</li> <li><input type="checkbox"/> Low Blood Pressure</li> <li><input type="checkbox"/> Lung Disease</li> <li><input type="checkbox"/> Mitral Valve Prolapse</li> <li><input type="checkbox"/> Pain in Jaw Joints</li> <li><input type="checkbox"/> Parathyroid Disease</li> <li><input type="checkbox"/> Prolonged Bleeding</li> <li><input type="checkbox"/> Psychiatric Care</li> <li><input type="checkbox"/> Radiation Treatments</li> <li><input type="checkbox"/> Recent Weight Loss</li> <li><input type="checkbox"/> Renal Dialysis</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Replaced Joints/Pins/Rods/Implants</li> <li><input type="checkbox"/> Rheumatic Fever</li> <li><input type="checkbox"/> Rheumatism</li> <li><input type="checkbox"/> Respiratory Problems</li> <li><input type="checkbox"/> Scarlet Fever</li> <li><input type="checkbox"/> Shingles</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Sickle Cell Disease</li> <li><input type="checkbox"/> Sinus Trouble</li> <li><input type="checkbox"/> Spina Bifida</li> <li><input type="checkbox"/> Stomach/Intestinal Disease</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Swelling of Limbs</li> <li><input type="checkbox"/> Thyroid Disease</li> <li><input type="checkbox"/> Tonsillitis</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Tumors or Growths</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Venereal Disease</li> <li><input type="checkbox"/> Yellow Jaundice</li> </ul> |
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If you have marked any of the illnesses above please explain:

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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 Gaurdian \_\_\_\_\_ Date: \_\_\_\_\_