EAST AURORA family dentistry
Know your dentist

Medical History

Patient Name: _____ Birthdate: _____ Date Created: _____

Please provide details if you select YES to the following questions.

Are you under a physicians care now?	yes ☐	no ☐	If yes:
Do you required premedication/antibiotic prior to dental treatment?	yes ☐	no ☐	If yes:
Have you ever been hospitalized or had a major operation?	yes ☐	no ☐	If yes:
Have you ever had a serious head or neck injury?	yes ☐	no ☐	If yes:
Are you taking any medications, pills, or drugs?	yes ☐	no ☐	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	yes ☐	no ☐	If yes:
Have you ever taken Fosamax, Boniva, Actonel, or any other medications continuing bisphosphorates?	yes ☐	no ☐	If yes:
Are you on a special diet?	yes ☐	no ☐	
Do you use tobacco? If yes, how much?	yes ☐	no ☐	If yes:

...

Women, are you:

Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐
Latex ☐ Sulfa drugs ☐ Local anesthetics ☐

Do you use controlled substances? yes ☐ no ☐ If yes:
Other? yes ☐ If yes:

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

AIDS/HIV Positive	yes ☐	no ☐	Frequent cough	yes ☐	no ☐
Alzheimer's Disease	yes ☐	no ☐	Frequent diarrhea	yes ☐	no ☐
Anaphalaxis	yes ☐	no ☐	Frequent headaches	yes ☐	no ☐
Anemia	yes ☐	no ☐	Genital herpes	yes ☐	no ☐
Angina	yes ☐	no ☐	Glaucoma	yes ☐	no ☐
Arthritis/Gout	yes ☐	no ☐	Hay fever	yes ☐	no ☐
Artificial heart valve	yes ☐	no ☐	Heart attack/failure	yes ☐	no ☐
Artificial joint	yes ☐	no ☐	Heart murmur	yes ☐	no ☐
Asthma	yes ☐	no ☐	Heart pacemaker	yes ☐	no ☐
Blood disease	yes ☐	no ☐	Heart trouble/disease	yes ☐	no ☐
Blood transfusion	yes ☐	no ☐	Hemophilia	yes ☐	no ☐
Breathing problems	yes ☐	no ☐	Hepatitis A	yes ☐	no ☐
Bruise easily	yes ☐	no ☐	Hepatitis B/C	yes ☐	no ☐
Cancer	yes ☐	no ☐	Herpes	yes ☐	no ☐
Chemotherapy	yes ☐	no ☐	High blood pressure	yes ☐	no ☐
Chest pains	yes ☐	no ☐	High cholesterol	yes ☐	no ☐
Cold sores/ fever blisters	yes ☐	no ☐	Hives/rash	yes ☐	no ☐
Congenital heart disorder	yes ☐	no ☐	Hypoglycemia	yes ☐	no ☐
Convulsions	yes ☐	no ☐	Irregular heartbeat	yes ☐	no ☐
Yellow jaundice	yes ☐	no ☐	Kidney problems	yes ☐	no ☐
Cortisone medicine	yes ☐	no ☐	Leukemia	yes ☐	no ☐
Diabetes	yes ☐	no ☐	Liver disease	yes ☐	no ☐
Drug addiction	yes ☐	no ☐	Low blood pressure	yes ☐	no ☐
Easily winded	yes ☐	no ☐	Lung disease	yes ☐	no ☐
Emphysema	yes ☐	no ☐	Mitral valve prolapse	yes ☐	no ☐
Epilepsy/sezures	yes ☐	no ☐	Osteoporosis	yes ☐	no ☐
Excessive bleeding	yes ☐	no ☐	Pain in jaw joints	yes ☐	no ☐
Excessive thirst	yes ☐	no ☐	Parathyroid disease	yes ☐	no ☐
Fainting spells/dizziness	yes ☐	no ☐	Psychiatric care	yes ☐	no ☐

Radiation treatments	yes ☐	no ☐	Stomach/intestinal disease	yes ☐	no ☐
Recent weight loss	yes ☐	no ☐	Stroke	yes ☐	no ☐
Renal dialysis	yes ☐	no ☐	Swelling of limbs	yes ☐	no ☐
Rheumatic fever	yes ☐	no ☐	Thyroid disease	yes ☐	no ☐
Rheumatism	yes ☐	no ☐	Tonsilitis	yes ☐	no ☐
Scarlet fever	yes ☐	no ☐	Tuberculosis	yes ☐	no ☐
Shingles	yes ☐	no ☐	Tumors/growths	yes ☐	no ☐
Sickle cell disease	yes ☐	no ☐	Ulcers	yes ☐	no ☐
Sinus trouble	yes ☐	no ☐	Venereal disease	yes ☐	no ☐
Spina bifida	yes ☐	no ☐			

Have you ever had any serious illness not listed above? yes ☐ no ☐ if yes:

Please enter your physicians's name and telephone number:

_____

Name of pharmacy, address, zip code for electronic claims:

_____

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 the 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: _____