NHD Medical History 2022.2

PATIENT NAME:_____ BIRTH DATE:_____ Date completed:_____

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

Do you see any physicians? O Yes O No Please list all of your current physicians

_____
_____
_____

Have you been hospitalized or had any operations? O Yes O No Please list

_____
_____
_____

Are you taking any medications, pills, drugs, supplements, or vitamins? O Yes O No Please list:

_____
_____
_____
_____

Have you ever taken any of the following medications containing bisphosphonates?

O **Fosamax** O **Boniva** O **Prolia** O **Other**

When and how long where they taken:_____

Have you ever had a serious head or neck injury? O Yes O No Please explain_____

Are you on a special diet? O Yes O No Please explain_____

Do you use tobacco or vapor? O Yes O No Please explain_____

Do you use any controlled substances? O Yes O No Please explain_____

WOMEN: Are you…

O Pregnant? O Nursing? O Using Birth Control (any type)? O Trying to get pregnant?

ALLERGIES: Are you allergic to any of the following

O Acrylic	O Aspirin	O Codeine	O Latex
O Local Anesthetics	O Metal	O Penicillin	O Sulfa Drugs

O Other_____

Please check any and all that apply to your current and past health

- O Acid Reflux/GERD
- O Anaphylaxis
- O Anxiety
- O Asthma
- O Breathing problems
- O Chest Pains
- O Convulsions
- O Depression
- O Emphysema
- O Fainting Spells/Dizziness
- O Frequent Headaches
- O Heart Attack/Failure
- O Heart Trouble/Disease
- O Hepatitis B
- O High Cholesterol
- O Ineffective Endocarditis
- O Liver Disease
- O Multiple Sclerosis
- O Parkinson's Disease
- O Renal Dialysis
- O Shingles
- O Sleep Disorders
- O Stroke
- O Tuberculosis
- O Yellow Jaundice
- O ADD/ADHD
- O Anemia
- O Arthritis/Gout
- O Autism Spectrum Disorder
- O Bruise Easily
- O Cold Sores/Fever Blisters
- O COPD
- O Diabetes
- O Epilepsy or Seizures
- O Fibromyalgia
- O Genital Herpes
- O Heart Murmur
- O Heart Valve Replacement
- O Hepatitis C
- O Hives or Rash
- O Irregular Heartbeat
- O Low Blood Pressure
- O Osteoporosis
- O Psychiatric Care
- O Rheumatic Fever
- O Sickle Cell Disease
- O Spina Bifida
- O Swelling of Limbs
- O Tumors or Growths
- O AIDS/HIV positive
- O Aneurysm
- O Artificial Joint
- O Blood Disease
- O Cancer
- O Congenital Heart Disorder
- O Cortisone Medicine
- O Drug Addiction
- O Excessive Bleeding
- O Frequent Cough
- O Glaucoma
- O Heart Pacemaker
- O Hemophilia
- O Herpes
- O Hypoglycemia
- O Kidney Problems
- O Lung Disease
- O Pain in Jaw Joints
- O Radiation Treatments
- O Rheumatism
- O Sinus Trouble
- O Stents
- O Thyroid Disease
- O Ulcers
- O Alzheimer's Disease
- O Angina
- O Asperger's
- O Blood Transfusion
- O Chemotherapy
- O Congestive Heart Failure
- O Dementia
- O Easily Winded
- O Excessive Thirst
- O Frequent Diarrhea
- O Hay Fever
- O Heart Transplant
- O Hepatitis A
- O High Blood Pressure
- O HPV (Human Papillomavirus)
- O Leukemia
- O Mitral Valve Prolapse
- O Parathyroid Disease
- O Recent Weight Loss
- O Scarlet Fever
- O Sjogren's Syndrome
- O Stomach/Intestinal Disease
- O Tonsilitis
- O Venereal Disease

Other Medical Condition? O Yes O No If yes, please list:

_____
_____
_____
_____
_____

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 **Date**