

# Medical History

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

|  |  |        |  |
|--|--|--------|--|
| Do you have a general physician? Please list your physician's name and number.                       | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |
| Have you ever been hospitalized or had a major operation? If so, when?                               | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |
| Have you ever had a serious injury to your head, neck, or mouth? If so, when?                        | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis?              | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |
| Have you ever had an orthopedic joint replacement? (hip, shoulder, knee, elbow, finger) If so, when? | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |
| Does your physician recommend antibiotics prior to dental appointments?                              | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |
| Are you on a special diet?   | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |
| Do you use tobacco? Which type and how often?  | <input type="radio"/> Yes <input type="radio"/> No | If yes |  |

Please list all prescription and over-the-counter medications that you are currently taking.

Women Only: Are you...

Pregnant/Trying to get pregnant?     
  Nursing?     
  Taking oral contraceptives?

Are you allergic to any of the following?

|                                  |                                     |                                      |  |
|----------------------------------|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine     | <input type="checkbox"/> Acrylic           |
| <input type="checkbox"/> Metal   | <input type="checkbox"/> Latex      | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local Anesthetics |

Other?  If yes

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

|                           |  |                           |  |                        |  |                             |  |
|---------------------------|--|---------------------------|--|------------------------|--|-----------------------------|--|
| Acid Reflux               | <input type="radio"/> Yes <input type="radio"/> No | Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia             | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease         | <input type="radio"/> Yes <input type="radio"/> No |
| ADHD                      | <input type="radio"/> Yes <input type="radio"/> No | COPD                      | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A            | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care/Depression | <input type="radio"/> Yes <input type="radio"/> No |
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C       | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatment         | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Dementia                  | <input type="radio"/> Yes <input type="radio"/> No | Herpes                 | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis              | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever             | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol       | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                  | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia           | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever               | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | Infective Endocarditis | <input type="radio"/> Yes <input type="radio"/> No | Shingles                    | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heart Beat   | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease         | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems        | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble               | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Leukemia               | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease  | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems        | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease          | <input type="radio"/> Yes <input type="radio"/> No | Stroke                      | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure     | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease             | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease           | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                 | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse  | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis                | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker           | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis           | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths           | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints     | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                      | <input type="radio"/> Yes <input type="radio"/> No |

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

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 Guardian: \_\_\_\_\_

X

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