



Medical History

Patient Name _____

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 medication you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under physician's care now? Yes No If yes: _____
Have you ever been hospitalized or had a major operation? Yes No If yes: _____
Have you ever had a serious neck injury? 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 containing bisphosphonates? Yes No If yes: _____
Are you on a special diet? Yes No If yes: _____
Do you use tobacco? Yes No If yes: _____
Do you use controlled substances? Yes No If yes: _____
Have you ever been required to take an antibiotic prior to a dental procedure? Yes No If yes: _____
Are you taking any medications, pills, or drugs? Yes No If yes: _____

WOMEN ONLY Are you:

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

Are you allergic to any of the following? (Please Circle)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs

Other? If yes, please explain: _____

Do you have, or have you ever had, any of the following:

Table with 4 columns of medical conditions and Yes/No response options. Includes conditions like AIDS/HIV, Diabetes, Heart Disease, etc.

If you have ever had a serious illness not listed above, OR, have any additional comments, please explain:

Signature of Patient, Parent or Guardian: _____ Date: _____