

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 If yes: _____ Yes No operation? Have you ever had a serious neck injury? Yes No If yes: Yes No Do you take, or have you taken, Phen-Fen or Redux? If yes: _____ Have you ever taken Fosamax, Boniva, Actonel or any Yes No If yes: _____ other medications containing bisphosphonates? Yes No If ves: Are you on a special diet? Yes No If yes: ____ Do you use tobacco? Do you use controlled substances? Yes No If yes: _____ Have you ever been required to take an antibiotic prior Yes No If yes: to a dental procedure? Are you taking any medications, pills, or drugs? Yes No If yes: _____ WOMEN ONLY Are you: Taking oral contraceptives? Yes No Pregnant/Trying to get pregnant? 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: **AIDS/HIV** Positive Yes No **Cortisone Medicine** No Hemophilia **Radiation Treatments** Yes No Yes Yes No Alzheimer's disease Yes No Hepatitis A No **Recent Weight Loss** Yes No Diabetes Yes No Yes Anaphylaxis Yes No Hepatitis B or C **Renal Dialysis** Yes No **Drug Addiction** Yes No Yes No Anemia Yes No Herpes **Rheumatic Fever** Yes No **Easily Winded** Yes No No Yes Yes No Yes High Blood Pressure Rheumatism Yes No Angina Emphysema No Yes No Arthritis/Gout No **High Cholesterol** Scarlet Fever No Yes **Epilepsy or Seizures** Yes No Yes No Yes Artificial Heart Valve Yes No Hives or Rash Shingles Yes No **Excessive Bleeding** Yes No Yes No Artificial Joint Yes No Hypoglycemia Sickle Cell Disease Yes No Excessive Thirst Yes No Yes No Sinus Trouble Asthma Yes No Irregular Heartbeat Yes No Fainting Spells/Dizziness Yes No Yes No Blood Disease Yes No **Kidney Problems** Spinal Bifida Yes No **Frequent Cough** Yes No Yes No **Blood Transfusion** Yes No No Leukemia Stomach/Intestinal Disease Yes No **Frequent Diarrhea** Yes Yes No **Breathing Problem** No Liver Disease Stroke No Yes Yes Yes **Frequent Headaches** No Yes No Low Blood Pressure Yes Swelling of Limbs No Bruise Easily Yes No **Genital Herpes** Yes No No Yes Thyroid Disease Cancer Yes No Glaucoma Yes No Lung Disease Yes No Yes No Chemotherapy Yes No No Mitral Valve Prolapse Yes Tonsillitis Yes No Hay Fever Yes No **Chest Pains** Yes No Osteoporosis Tuberculosis Yes No Heart Attack/Failure Yes No Yes No Cold Sores/Fever Blisters Yes No Tumors or Growths No Pain in Jaw Joints Yes Heart Murmur Yes No Yes No Parathyroid Disease Yes Congenital Heart No Yes No Heart Pacemaker Yes No No Ulcers Yes Disorder Yes No Heart Trouble/Disease No **Psychiatric Care** Yes No Venereal Disease Yes No Yes

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

Yellow Jaundice

Yes

No