# Patient Medical History

Patient Name:_________________________________ Birth Date:___________________

**(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 that you are taking, can affect your oral health).**

Are you under a physician's care now and for what?___________________________________________________

Have you ever been hospitalized and/or surgeries?____________________________________________________

Have you ever had a serious head or neck injury?_____________________________________________________

Do you use tobacco & how much? ____________________________ Any Special Diet?__________________

Are you on any medications?____________________________________________________________________

Have you ever taken **Fosamax, Boniva, Actonel,** or any other medication containing **bisphosphonates**?_______________

Are you Pregnant/Trying to get Pregnant?_____________ Nursing?________ Oral Contraceptives?______________

**Any Known Allergies? Latex, Penicillin, Codeine etc.**_________________________________________________
**Do you use Controlled Substances?**______________

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

| Condition | Y | N |
|---|---|---|
| **AIDS/HIV Positive** | **Y** | **N** |
| **Alzheimer's Disease** | **Y** | **N** |
| **Anaphylaxis** | **Y** | **N** |
| **Anemia** | **Y** | **N** |
| **Arthritis/Gout** | **Y** | **N** |
| **Artificial Heart Valve** | **Y** | **N** |
| **Artificial Joint** | **Y** | **N** |
| **Asthma** | **Y** | **N** |
| **Blood Disease** | **Y** | **N** |
| **Blood Transfusion** | **Y** | **N** |
| **Breathing Problems** | **Y** | **N** |
| **Bruise Easily** | **Y** | **N** |
| **Cancer** | **Y** | **N** |
| **Chemotherapy** | **Y** | **N** |
| **Chest Pains** | **Y** | **N** |
| **Cold Sores/Fever Blister** | **Y** | **N** |
| **Cortisone Medicine** | **Y** | **N** |
| **Diabetes** | **Y** | **N** |
| **Drug Addiction** | **Y** | **N** |
| **Emphysema** | **Y** | **N** |
| **Epilepsy/Seizure** | **Y** | **N** |
| **Excessive Bleeding** | **Y** | **N** |
| **Excessive Thirst** | **Y** | **N** |
| **Fainting Spells/Dizziness** | **Y** | **N** |
| **Frequent Cough** | **Y** | **N** |
| **Frequent Headaches** | **Y** | **N** |
| **Glaucoma** | **Y** | **N** |
| **Hay Fever** | **Y** | **N** |
| **Heart Murmur** | **Y** | **N** |
| **Heart Pace Maker** | **Y** | **N** |

| Condition | Y | N |
|---|---|---|
| **Hepatitis A, B, & C** | **Y** | **N** |
| **Herpes** | **Y** | **N** |
| **High Blood Pressure** | **Y** | **N** |
| **High Cholesterol** | **Y** | **N** |
| **Hypoglycemia** | **Y** | **N** |
| **Kidney Problems** | **Y** | **N** |
| **Leukemia** | **Y** | **N** |
| **Liver Disease** | **Y** | **N** |
| **Low Blood Pressure** | **Y** | **N** |
| **Lung Disease** | **Y** | **N** |
| **Mitral Valve Prolapse** | **Y** | **N** |
| **Pain in Jaw Joints** | **Y** | **N** |
| **Psychiatric Care** | **Y** | **N** |
| **Radiation Treatment** | **Y** | **N** |
| **Recent Weight Loss** | **Y** | **N** |
| **Renal Dialysis** | **Y** | **N** |
| **Scarlet Fever** | **Y** | **N** |
| **Shingles** | **Y** | **N** |
| **Sickle Cell Disease** | **Y** | **N** |
| **Sinus Trouble** | **Y** | **N** |
| **Stomach/Intestinal Disease** | **Y** | **N** |
| **Stroke** | **Y** | **N** |
| **Swelling of Limbs** | **Y** | **N** |
| **Thyroid Disease** | **Y** | **N** |
| **Tonsillitis** | **Y** | **N** |
| **Tuberculosis** | **Y** | **N** |
| **Tumors of Growths** | **Y** | **N** |
| **Ulcers** | **Y** | **N** |
| **Yellow Jaundice** | **Y** | **N** |

**Have you ever had any serious illness not listed ___Y ___N If Yes** ____________________________________

**Sign/Date**
______________________________________________________________________________