MEDICAL HISTORY

Patient Name: _____ Birthdate: _____

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

If you answer yes to the following questions, please explain on the blank provided.	YES	NO
Are you under a physician's care now? _____	☐	☐
Have you ever been hospitalized or had a major operation? _____	☐	☐
Have you ever had a serious head or neck injury? _____	☐	☐
Are you taking any medications, pills, or drugs? _____	☐	☐
If yes, please provide a MED LIST: _____		
Do you take, or have you taken Fen-Phen or Redux? _____	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? _____	☐	☐
Are you on a special diet? _____	☐	☐
Do you use tobacco? _____	☐	☐
Do you use controlled substances? _____	☐	☐

* Women, are you: (circle all that apply) Pregnant/ Possibly pregnant _____months Taking oral contraceptives Nursing

Are you allergic to any of the following? _____ ☐ No Known Allergies

☐ Aspirin/NSAIDs ☐ Penicillin/Antibiotics ☐ Codeine ☐ Local Anesthestics ☐ Bleach ☐ Iodine ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Food: _____ ☐ Other; If yes, please explain: _____

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

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Recent Weight Loss	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Renal Dialysis	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatism	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Shingles	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Sickle Cell Disease	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Stomach/Intestinal	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Disease		
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Liver Disease/Cirrhosis	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
						Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐

Have you every had any serious illness not listed above? _____

Has a physician or dentist ever recommended that you take antibiotics prior to dental treatment? ☐ YES ☐ NO

Comments: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

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

SUCCESSFUL SMILES