MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

List all physicians that you see, their office phone numbers & what they are seen for:_____

_____

_____

_____

List all Hospitalizations/Major Surgeries/Major Illnesses & when they occurred (If you need more room, there is another form): _____

_____

_____

List serious head or neck injuries & when they occurred:_____

_____

If you are taking, or have you ever taken, Bisphosphonate drugs to strengthen bones? (Actonel, Aredia, Bonefos, Boniva, Didronel, Fosamax, Ostac, Skelid, Zometa, etc, what & how long: _____

_____

List all other medications, pills or drugs & what they are taken for (If you need more room, there is another form):_____

_____

_____

_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No. If yes, what & how long: _____

If yes, have you had an ECHO ☐ Yes ☐ No Was it clear? ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes ☐ No If yes, what & approx. how much daily? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much daily? _____

Do you use controlled substances/recreational drugs? ☐ Yes ☐ No If yes, what & for what reason? _____

_____

Are you pregnant / trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Are you ALLERGIC to any of the following?

ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ METAL ☐ LATEX ☐ LOCAL ANESTHETICS ☐

List any other allergies or sensitivities: _____

_____

_____

_____

Do you have any history of any of the following?

AIDS/HIV Positive	☐ Y ☐ N	Cortisone Medicine	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Renal Dialysis	☐ Y ☐ N
Alzheimer's Disease	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Hepatitis A	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Anaphylaxis	☐ Y ☐ N	Drug Addiction	☐ Y ☐ N	Hepatitis B or C	☐ Y ☐ N	Rheumatism	☐ Y ☐ N
Anemia	☐ Y ☐ N	Easily Winded	☐ Y ☐ N	Herpes	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Angina	☐ Y ☐ N	Emphysema	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Shingles	☐ Y ☐ N
Arthritis/Gout	☐ Y ☐ N	Epilepsy or Seizures	☐ Y ☐ N	Hives or Rash	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
Artificial Heart Valve	☐ Y ☐ N	Excessive Bleeding	☐ Y ☐ N	Hypoglycemia	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N
Artificial Joint	☐ Y ☐ N	Excessive Thirst	☐ Y ☐ N	Irregular Heartbeat	☐ Y ☐ N	Spina Bifida	☐ Y ☐ N
Asthma	☐ Y ☐ N	Fainting Spells/Dizziness	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Stomach/intestinal Disease	☐ Y ☐ N
Blood Disease	☐ Y ☐ N	Frequent Cough	☐ Y ☐ N	Leukemia	☐ Y ☐ N	Stroke	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Frequent Diarrhea	☐ Y ☐ N	Liver Disease	☐ Y ☐ N	Swelling of Limbs	☐ Y ☐ N
Breathing Problem	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Bruises Easily	☐ Y ☐ N	Genital Herpes	☐ Y ☐ N	Lung Disease	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Cancer	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Chemotherapy	☐ Y ☐ N	Hay Fever	☐ Y ☐ N	Pain in Jaw Joints	☐ Y ☐ N	Tumors or Growths	☐ Y ☐ N
Chest Pains	☐ Y ☐ N	Heart Attack/Failure	☐ Y ☐ N	Parathyroid Disease	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Cold Sores/Fever Blisters	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
Congenital Heart Disorder	☐ Y ☐ N	Heart Pace Maker	☐ Y ☐ N	Radiation Treatment	☐ Y ☐ N	Yellow Jaundice	☐ Y ☐ N
Convulsions	☐ Y ☐ N	Heart Trouble/Disease	☐ Y ☐ N	Recent Weight Loss	☐ Y ☐ N	Alcoholism	☐ Y ☐ N

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, Please explain. _____

_____

_____

_____

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_____ **Date**_____

(Parent or guardian to sign if patient is under 18 years of age)