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

Are you under a physician's care now? Yes No If yes, please explain: ____

Have you ever been hospitalized or had a major operation, or had a serious head or neck injury? Yes No If yes, please explain: ____

Are you taking any medications, pills, or drugs? Yes No List Here: ____
____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Have you ever taken or are you taking any blood thinners? Yes No

Do you use tobacco, e-cigarettes, chewing tobacco? Yes No

Do you use controlled substances or have history of drug addiction? Yes No

Do you need to pre-medicate before dental procedures? Yes No

Do you snore, have excessive daytime sleepiness, or suspect you have sleep apnea or other sleeping disorders? Yes No

Women: 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?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Other

If Other, please list:____

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

High Blood Pressure	Yes	No	High Cholesterol	Yes	No	Hepatitis A, B, or C	Yes	No	Psychiatric Care	Yes	No
Low Blood Pressure	Yes	No	Artificial Joint	Yes	No	AIDS/HIV Positive	Yes	No	Anxiety	Yes	No
Heart Trouble/Disease	Yes	No	Cancer	Yes	No	Venereal Disease	Yes	No	Depression	Yes	No
Heart Murmur	Yes	No	Chemotherapy/Radiation	Yes	No	Blood Disease	Yes	No	Dementia/Alzheimer's	Yes	No
Artificial Heart Valve	Yes	No	Tumors or Growths	Yes	No	Blood Transfusion	Yes	No	Osteoporosis	Yes	No
Heart Pacemaker	Yes	No	Thyroid Disease	Yes	No	Rheumatism	Yes	No	Stroke	Yes	No
Congestive Heart Failure	Yes	No	Parathyroid Disease	Yes	No	Rheumatic Fever	Yes	No	Swelling of Extremities	Yes	No
Mitral Valve Prolapse	Yes	No	Eye Disease	Yes	No	Anemia	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Excessive Bleeding	Yes	No	Arthritis/Gout	Yes	No
Hypoglycemia	Yes	No	Renal Dialysis	Yes	No	Bruise Easily	Yes	No	Excessive Thirst	Yes	No
Excessive Snoring	Yes	No	Shingles	Yes	No	Environmental Allergies	Yes	No	Fainting Spells/Dizziness	Yes	No
Sleep Apnea	Yes	No	Lung Disease	Yes	No	Food Allergies	Yes	No	Liver Disease	Yes	No
Sinus Trouble	Yes	No	Asthma	Yes	No	Tonsillitis	Yes	No	Stomach/Intestinal Disease	Yes	No
Pain in Jaw Joints	Yes	No	GERD/Acid Reflux	Yes	No	Cold or Canker Sores	Yes	No	Frequent Cough	Yes	No
Frequent Neck Pain	Yes	No	Frequent Headaches	Yes	No						

Please explain all YES answers here: ____
____
____
____

Do you have or have you had any other serious illnesses or conditions not listed on this form? 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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE ____________________