Medical History

Patient Name: _____
Last First Middle

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer: _____

Occupation: _____ Height: _____ Weight: _____

SS#: _____ Date of Birth: _____ Sex: Male Female

Physician: _____

Dental Insurance: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Home Phone: _____ Cell Phone: _____

Married: Yes No Spouse's Name: _____

List any medication that you are currently taking:

_____

_____

_____

_____

_____

_____

Medical History

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and area in and around your mouth, your mouth us a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important the interrelationship with dentistry you will received. 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? ☐ Yes ☐ No
If Yes, please explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If Yes, please explain _____

Are you taking medication, pills or drugs? ☐ Yes ☐ No
If Yes, please explain _____

Are you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
If Yes, please explain _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
If Yes, please explain _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No
If Yes, please explain _____

Women: Are you …

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Others If Yes, _____

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

AIDS/HIV Positive	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Chest Pains	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Congenital Heart Disorder	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No

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

Breathing Problems	☐ Yes	☐ No	Emphysemas	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
GE Reflux/Heartburn	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Genital Herpes	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Hepatitis A	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Hepatitis B or C	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Hives or Rash	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Yellow Jaundice		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If Yes, _____

Comments:

_____

_____

_____

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 of Patient, Parent or Guardian:

X _____ Date: _____