MEDICAL HISTORY

Patient Name_____ **Birth Date**_____

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 any medications, pills or drugs? ◯ Yes ◯ No If yes, please explain:_____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you:
Pregnant ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics
◯ Sulfa Drugs ◯ Other If yes, please explain:_____

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

AIDS/HIV Positive	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting/Dizziness	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Tumors or Growth	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Heart Trouble/ Diseases	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No			Renal Dialysis	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
				Rheumatic Fever	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:_____

_____

Have you ever taken any of the following medications?

Actonel ◯ Yes ◯ No
Aredia ◯ Yes ◯ No
Fosamax ◯ Yes ◯ No
Reclast ◯ Yes ◯ No
Zometa ◯ Yes ◯ No
Boniva ◯ Yes ◯ No
Herbal ◯ Yes ◯ No
Supplements

Are you under a physician's care? If yes, please explain?

_____

_____
Family Physician Phone number

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 _____ DATE_____