Medical History

PATIENT NAME _____

Although dental personnel treat the area in and around the mouth, your mouth is 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, _____

Have you ever been hospitalized or had a major operation? ___Yes __No If yes, _____

Have you ever had a serious head or neck injury? ___Yes __No If yes, _____

Are you taking any medication, pills or drugs? ___Yes __No If yes, _____

Do you take, or have taken, Phen-Fen or Redux? ___Yes __No If yes, _____

Have you ever taken Fosamax Boniva, Actonel or any other medications containing bisphosphonates? ___Yes __No If yes, _____

Are you on a special diet? ___Yes __No Do you use controlled substances? ___Yes __ No
Do you use tobacco? ___Yes __No
Women: Are you ____Pregnant/Trying to get pregnant? ____Nursing? ____Taking oral contraceptives?

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medications is complete. Please consult with your physician for further guidance.

Are you allergic to any of the following?

__Aspirin __Penicillin __Codeine __Acrylic __Metal __Latex __Sulfa Drugs __Local Anesthetics

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

__AIDS/HIV Positive	__Cold sores/fever blisters	__Glaucoma	__Leukemia	__Sickle cell disease
__Alzheimer's disease	__Congenital heart disorder	__Hay Fever	__Liver disease	__Sinus trouble
__Anaphylaxis	__Convulsions	__Heart attack/failure	__Low blood pressure	__Spina Bifida
__Anemia	__Cortisone medicine	__Heart murmur	__Lung disease	__Stomach/Intestinal Disease
__Angina	__Diabetes	__Heart pace maker*	__Mitral Valve Prolapse	__Stroke
__Arthritis/Gout	__Drug addiction	__Heart troubles/disease	__Osteoporosis	__Swelling of limbs
__Artificial heart valve*	__Easily winded	__Hemophilia	__Pain in Jaw Joints	__Thyroid disease
__Artificial joint*	__Emphysema	__Hepatitis A	__Parathyroid Disease	__Tonsillitis
__Asthma	__Epilepsy or seizures	__Hepatitis B or C	__Psychiatric Care	__Tuberculosis
__Blood disease	__Excessive bleeding	__Herpes	__Radiation treatments	__Tumors or growths
__Blood transfusion	__Excessive thirst	__High blood pressure	__Recent weight loss	__Ulcers
__Breathing problem	__Fainting spells/dizziness	__High Cholesterol	__Renal dialysis	__Venereal disease
__Bruise easily	__Frequent cough	__Hives or rash	__Rheumatic fever*	__Yellow jaundice
__Cancer	__Frequent diarrhea	__Hypoglycemia	__Rheumatism	
__Chemotherapy	__Frequent headaches	__Irregular heartbeat	__Scarlet fever	
__Chest pain	__Genital herpes	__Kidney problems	__Shingles	

Have you ever had any serious illness not listed above? ___Yes ___No
Comments:_____
_____
Date of last dental treatment:_____ Dental service received:_____
Describe chief dental concern:_____

*Condition may require medication

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

Medical History Update

My initials indicate that I have reviewed the above medical history and believe it to be true on the date specified, and I consent to routine procedures deemed necessary for diagnosis and treatment.

_____ _____
Initials Date