

MEDICAL HISTORY

Patient Name: _____

Birth date: _____

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

List all hospitalizations, major surgeries & a major illness and approximate dates: _____

List any upcoming surgeries / medical procedures? _____

List any serious head or neck injuries and approximate dates: _____

Have you experienced any adverse reactions during dental procedures? If so, what & when: _____

Have you ever taken, drugs to strengthen bones? (Actonel, Aredia, Bonafos, Boniva, Didronel, Fosamax, Ostac, Skelid, Zometa, etc.)
If yes, list drug names, start dates, and last dates taken, how often it is taken & in what form (Oral, IV, injection).

Have you taken, Phen-Fen or Redux? How long? _____ If yes, have you had a clear ECHO? Yes No

Have you ever used tobacco products ? Yes No If yes, what, when & approx. how much daily? _____

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

Have you ever used controlled substances/recreational drugs? Yes No If yes, what & when: _____

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 SHELLFISH / IODINE

List all other allergies or sensitivities: _____

have any history of any of the following?

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

List any serious illness or medical condition not listed above: _____

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

Date _____