Medical History

Patient Name: _____ Date of Birth:_____

Are you under a physician's care now? ▢ yes ▢ no If yes, please explain _____
Have you recently been hospitalized? ▢ yes ▢ no If yes, please explain _____
Are you taking any medications, pills, or drugs? ▢ yes ▢ no If yes, please list:
_____
Do you take or have you taken Phen-Fen or Redux? ▢ yes ▢ no
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ▢ yes ▢ no
Are you on a special diet? ▢ yes ▢ no
Do you use tobacco? ▢ yes ▢ no
Do you use controlled substances? ▢ yes ▢ no

Women: Are you:
Pregnant or trying to get pregnant? ▢ yes ▢ no
Taking oral contraceptives? ▢ yes ▢ no

Are you allergic to any of the following?

▢ Aspirin ▢ Penicillin ▢ Codeine ▢ Local anesthetics ▢ Acrylic
▢ Metal ▢ Latex ▢ Sulfa drugs ▢ other _____

Do you or have you ever pre-medicated for dental visits? Yes/No

Do you have or have had any of the following?

AIDS/HIV positive	▢ yes	▢ no			
Alzheimer's Disease	▢ yes	▢ no	Blood disease	▢ yes	▢ no
Anaphylaxis	▢ yes	▢ no	Blood transfusion	▢ yes	▢ no
Anemia	▢ yes	▢ no	Breathing problems	▢ yes	▢ no
Angina	▢ yes	▢ no	Bruise easily	▢ yes	▢ no
Arthritis/Gout	▢ yes	▢ no	Cancer	▢ yes	▢ no
Artificial Heart Valve	▢ yes	▢ no	Chemotherapy	▢ yes	▢ no
Artificial jointA	▢ yes	▢ no	Chest pain	▢ yes	▢ no
Asthma	▢ yes	▢ no	Cold sores/fever blisters	▢ yes	▢ no

Congenital heart disorder	▢ yes	▢ no	Irregular heartbeat	▢ yes	▢ no
Convulsions	▢ yes	▢ no	Kidney problems	▢ yes	▢ no
Cortisone medicine	▢ yes	▢ no	Leukemia	▢ yes	▢ no
Diabetes	▢ yes	▢ no	Liver disease	▢ yes	▢ no
Drug addiction	▢ yes	▢ no	Low blood pressure	▢ yes	▢ no
Easily winded	▢ yes	▢ no	Lung disease	▢ yes	▢ no
Emphysema	▢ yes	▢ no	Mitral valve prolapse	▢ yes	▢ no
Epilepsy or seizures	▢ yes	▢ no	Osteoporosis	▢ yes	▢ no
Excessive bleeding	▢ yes	▢ no	Pain in jaw joints	▢ yes	▢ no
Excessive thirst	▢ yes	▢ no	Parathyroid disease	▢ yes	▢ no
Fainting spells/dizziness	▢ yes	▢ no	Psychiatric care	▢ yes	▢ no
Frequent cough	▢ yes	▢ no	Radiation treatments	▢ yes	▢ no
Frequent diarrhea	▢ yes	▢ no	Recent weight loss	▢ yes	▢ no
Frequent headaches	▢ yes	▢ no	Renal dialysis	▢ yes	▢ no
Genital Herpes	▢ yes	▢ no	Rheumatic fever	▢ yes	▢ no
Glaucoma	▢ yes	▢ no	Rheumatism	▢ yes	▢ no
Hay fever	▢ yes	▢ no	Scarlet fever	▢ yes	▢ no
Heart attack/failure	▢ yes	▢ no	Shingles	▢ yes	▢ no
Heart Murmur	▢ yes	▢ no	Sickle cell disease	▢ yes	▢ no
Heart Pacemaker	▢ yes	▢ no	Sinus trouble	▢ yes	▢ no
Heart Trouble/disease	▢ yes	▢ no	Stomach/intestinal disease	▢ yes	▢ no
Hepatitis A	▢ yes	▢ no	Stroke	▢ yes	▢ no
Hemophilia	▢ yes	▢ no	Swelling of limbs	▢ yes	▢ no
Hepatitis B or C	▢ yes	▢ no	Thyroid disease	▢ yes	▢ no
Herpes	▢ yes	▢ no	Tonsillitis	▢ yes	▢ no
High blood pressure	▢ yes	▢ no	Tuberculosis	▢ yes	▢ no
High cholesterol	▢ yes	▢ no	Tumors or growths	▢ yes	▢ no
Hives or rash	▢ yes	▢ no	Ulcers	▢ yes	▢ no
Hypoglycemia	▢ yes	▢ no	Venereal disease	▢ yes	▢ no

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the doctor of any changes to my medical status.

_____ _____

Signature of patient, parent or guardian Date