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family dentistry

Patient Name: _____ Birth Date: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important connection 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, 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 any medications, pills, or drugs? ☐ **YES** ☐ **NO** **If yes, please explain:**
Do 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? ☐ **YES** ☐ **NO** Nursing? ☐ **YES** ☐ **NO** Taking oral contraceptives? ☐ **YES** ☐ **NO**
Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other **if yes, please explain:**

Please complete other side

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Do you have, or have you had, any of the following? **(Please mark each line individually)**

AIDS/HIV Positive	☐ YES	☐ NO	Hepatitis A	☐ YES	☐ NO
Alzheimer's Disease	☐ YES	☐ NO	Hepatitis B or C	☐ YES	☐ NO
Anaphylaxis	☐ YES	☐ NO	Herpes	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO
Angina	☐ YES	☐ NO	High Cholesterol	☐ YES	☐ NO
Arthritis/Gout	☐ YES	☐ NO	Hives or Rash	☐ YES	☐ NO
Artificial Heart Valve	☐ YES	☐ NO	Hypoglycemia	☐ YES	☐ NO
Artificial Joint	☐ YES	☐ NO	Irregular Heartbeat	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Kidney Problems	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO	Leukemia	☐ YES	☐ NO
Blood Transfusion	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO
Breathing Problems	☐ YES	☐ NO	Low Blood Pressure	☐ YES	☐ NO
Bruise Easily	☐ YES	☐ NO	Lung Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Mitral Valve Prolapse	☐ YES	☐ NO
Chemotherapy	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
Chest Pains	☐ YES	☐ NO	Pain in Jaw Joints	☐ YES	☐ NO
Cold Sores/Fever Blisters	☐ YES	☐ NO	Parathyroid Disease	☐ YES	☐ NO
Congenital Heart Disorder	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO
Convulsions	☐ YES	☐ NO	Radiation Treatments	☐ YES	☐ NO
Cortisone Medicine	☐ YES	☐ NO	Recent Weight Loss	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Renal Dialysis	☐ YES	☐ NO
Drug Addiction	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Easily Winded	☐ YES	☐ NO	Rheumatism	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Scarlet Fever	☐ YES	☐ NO
Epilepsy or Seizures	☐ YES	☐ NO	Shingles	☐ YES	☐ NO
Excessive Bleeding	☐ YES	☐ NO	Sickle Cell Disease	☐ YES	☐ NO
Excessive Thirst	☐ YES	☐ NO	Sinus Trouble	☐ YES	☐ NO
Fainting Spells/Dizziness	☐ YES	☐ NO	Spina Bifida	☐ YES	☐ NO
Frequent Cough	☐ YES	☐ NO	Stomach/Intestinal Disease	☐ YES	☐ NO
Frequent Diarrhea	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Frequent Headaches	☐ YES	☐ NO	Swelling of Limbs	☐ YES	☐ NO
Genital Herpes	☐ YES	☐ NO	Thyroid Disease	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO	Tonsillitis	☐ YES	☐ NO
Hay Fever	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Heart Attack/Failure	☐ YES	☐ NO	Tumors or Growths	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO
Heart Pacemaker	☐ YES	☐ NO	Venereal Disease	☐ YES	☐ NO
Heart Trouble/Disease	☐ YES	☐ NO	Yellow Jaundice	☐ YES	☐ NO
Hemophilia	☐ YES	☐ NO			

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.

X _____ **Date:** _____

(Signature of Patient, Parent or Guardian)