

**MEDICAL HISTORY**

Have you taken Bisphosphonate drugs such as Fosomax, Boniva, Zometa, etc.?

Yes \_\_\_\_\_ No \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If yes, please specify

Are you under a physician's care now? No Yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation? No Yes \_\_\_\_\_

Have you ever had a serious head or neck injury? No Yes \_\_\_\_\_

Are you taking any medications, pills, or drugs? No Yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? No Yes \_\_\_\_\_

Are you on a special diet? No Yes \_\_\_\_\_

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above? Yes No N/A

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\* Condition may require medication BP \_\_\_\_\_ Pulse \_\_\_\_\_

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 \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_