MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

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 impact on 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:_____
Do you currently use or have you used a Hard Night Guard?	Yes ☐	No ☐	If yes, please explain:_____
Are you on a special diet?	Yes ☐	No ☐	If yes, please explain:_____
Do you take, or have you taken, bisphosphonate such as Fosamax, Boniva, Zometa or Actonel?	Yes ☐	No ☐	If yes, please explain:_____
Do you currently use, or have you used tobacco in the past?	Yes ☐	No ☐	If yes, please explain:_____
Do you currently use or have you used drugs in the past?	Yes ☐	No ☐	If yes, please explain:_____

List any medications or supplements you are currently taking:

Name of Medication	Dosage	Reason for taking

Women: Are you Pregnant/Trying to get pregnant? Yes ☐ No ☐ Taking oral contraceptives? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

If yes, please explain_____

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

Acid Reflux	Yes ☐ No ☐	Cortisone Medicine	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐
AIDS/HIV Positive	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Heart Pace Maker	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐
Alzheimer's Disease	Yes ☐ No ☐	Drug Addiction	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐	Weight Loss	Yes ☐ No ☐
Anaphylaxis	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Hepatitis A, B or C	Yes ☐ No ☐	Renal Dialysis	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Endocarditis	Yes ☐ No ☐	Herpes	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Arthritis/Gout	Yes ☐ No ☐	Epilepsy/Seizures	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Excessive Bleeding	Yes ☐ No ☐	Hypoglycemia	Yes ☐ No ☐	Sinus Problems	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐	Excessive Thirst	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐	Stomach Problems	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Fainting/Dizziness	Yes ☐ No ☐	Leukemia	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Thyroid Disease	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Hay Fever	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐	Tonsillitis	Yes ☐ No ☐
Chest Pains	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Lung Disease	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Clench or Grind Teeth	Yes ☐ No ☐	Heart Attack	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐	Tumors	Yes ☐ No ☐
Cold Sores	Yes ☐ No ☐	Irregular Heartbeat	Yes ☐ No ☐	Pain in Jaw Joints	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Colitis	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐	Parathyroid Disease	Yes ☐ No ☐		

Have you ever had any serious illness not listed above? Yes ☐ No ☐ If yes, please explain:_____

Physician: _____ Phone Number:_____

Comments: _____

In Case of Emergency Contact: _____ Phone Number: _____

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**_____