Medical History Form

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:

Do you have, or have you had any of the following in the last year?

Aids O
HIV Positive O
Alzheimer's O
Anaphylaxis O
Anemia O
Angina O
Arthritis O
Artificial Heart Valve O
Artificial Joint O
Asthma O
Blood Disease O
Blood Transfusion O
Breathing Problems O
Bruise Easily O
Cancer O
Chemotherapy O
Chest Pains O
Cold Sores O
Congenital Heart Disorder O
Convulsions O
Cortisone Medication O
Diabetes O
Drug Addiction O
Easily Winded O
Emphysema O
Epilepsy/Seizures O
Excessive Bleeding O

Excessive Thirst O
Fainting O
Dizziness O
Frequent Cough O
Headaches O
Glaucoma O
Hay Fever O
Heart Attack O
Heart Failure O
Pacemaker O
Heart Disease O
Hemophilia O
Hep A B or C O
High Blood Pressure O
High Cholesterol O
Hives or Rash O
Hypoglycemia O
Irregular Heartbeat O
Kidney Problems O
Leukemia O
Liver Disease O
Low Blood Pressure O
Lung Disease O
Mitral Valve Prolapse O
Osteoporosis O
Pain in Jaw Joints O
Parathyroid Disease O
Psychiatric Care O
Radiation Treatment O

Renal Dialysis O
Rheumatic Fever O
Rheumatism O
Scarlet Fever O
Shingles O
Sickle Cell Disease O
Sinus Trouble O
Skin Rash O
Spina Bifida O
Special Diet O
Stomach/Intestinal Disease O
Stroke O
Swelling of Feet/Ankles O
Thyroid Disease O
Tonsillitis O
Tuberculosis O
Tumors or Growths O
Ulcers O
Weight Loss O
STD O

Other:
____
____
____
____
____
____

Are you allergic or have you had any adverse reaction to any of the following? Please Circle

Aspirin Local Anesthetics Latex Ibuprofen
Penicillin Acrylic Sulfa Drug Tylenol
Codeine Metal Barbiturates Other: ________________________________

Are you experiencing any pain or discomfort? Yes No

If yes, please explain: ________________________________

Is there anything you don't like about your smile?

Discolored Teeth Spaces or Gaps Bad Breath
Crooked Teeth Silver Fillings Other: ________________________________

Patient Signature: ________________________ Date: ________________

Medical History Form

Please List any medications/drugs that you are currently taking:

____

____

____

Are you under a physician's care? Yes No
If yes, please explain:

____

____

____

Have you been hospitalized or had any major operations in the last year? Yes No
If yes, please explain:

____

____

____

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

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women:
Are you pregnant or trying to get pregnant? Yes No

If yes, what is your expected due date? ____

Are you currently nursing? Yes No

Are you taking oral contraceptives? Yes No

Patient Signature: _________________________ **Date: _____________**