****

 **MEDICAL HISTORY**

**PATIENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **BIRTHDATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Although our dental team primarily treats the area in and around your mouth, your mouth is a significant link to your entire body. Health problems that you may have, or medication that you may be taking could have an importance interrelationship 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 [ ] 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 [ ] If yes, what type and how often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use controlled substances? Yes [ ] No [ ]

**Women: Are you?**

Pregnant? Yes[ ] No[ ] Trying to Conceive? Yes[ ] No[ ] Taking Oral Contraceptives? Yes[ ] No[ ] Nursing? Yes[ ] No[ ]

**Are you allergic to any of the following?**

Aspirin [ ] Penicillin [ ] Codeine [ ] Local Anesthetics [ ] Acrylic [ ] Metal [ ]

Latex [ ] Sulfa Drugs [ ] Other [ ] If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have, or have you had, any of the following(If yes, please circle)?**

AIDS/HIV Positive

Alzheimer’s Disease

Anaphylaxis

Anemia

Angina

Arthritis/Gout

Artificial Heart Valve

Artificial Joint

Asthma

Blood Disease

Blood Transfusion

Breathing Problem

Bruise Easily

Cancer

Chemotherapy

Chest Pains

Cold Sores/Fever Blisters

Congenital Heart Disorder

Convulsions

Cortisone Medicine

Diabetes

Drug Addiction

Easily Winded

Emphysema

Epilepsy or seizures

Excessive Bleeding

Excessive Thirst

Fainting Spells/Dizziness

Frequent Cough

Frequent Headaches

Genital Herpes

Glaucoma

Hay Fever

Heart Attack/Failure

Heart Murmur

Heart Pacemaker

Heart Trouble/Disease

Hemophilia

Hepatitis A

Hepatitis B or C

Herpes

High Blood Pressure

High Cholesterol

Hives or Rash

Hypoglycemia

Irregular Heartbeat

Kidney Problems

Leukemia

Liver Disease

Low Blood Pressure

Lung Disease

Mitral Valve Prolapse

Osteoporosis

Pain in Jaw Joints

Parathyroid Disease

Psychiatric Care

Radiation Treatments

Recent Weight Loss

Renal Dialysis

Rheumatic Fever

Rheumatism

Scarlet Fever

Shingles

Sickle Cell Disease

Sinus Trouble

Spina Bifida

Stomach/Intestinal Disease

Stroke

Swelling of Limbs

Thyroid Disease

Tonsilitis

Tuberculosis

Tumors or Growths

Ulcers

Veneral Disease

Yellow Jaundice

**Have you ever had any serious illness not listed above?** Yes [ ] No [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 health. It is my responsibility to inform the dental office of any changes in medical status.**

Signature of Patient/Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_