Medical History Default

Patient Name: Birth Date: Date Created:

Are you under a physician's care?	◯ Yes ◯ No	If yes
Have you been hospitalized or had major surgery recently?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you take NSAID Pain reliever, Anti-Inflammatory, Anti-Histamine, Blood Thinner, Anti-Anxiety?	◯ Yes ◯ No	If yes
Do you use tobacco, smokeless or vape?	◯ Yes ◯ No	If yes

Women: Are you...

Pregnant/Trying to get pregnant?	◯ Yes ◯ No	Nursing?	◯ Yes ◯ No	Taking contraceptives?	◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes

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.

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

AIDS/HIV Positive ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Anemia (Blood Disease) ◯ Yes ◯ No
Angina (chest pain) ◯ Yes ◯ No	Arthritis/Rheumatism/Gout ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Cancer ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Cold Sores/herpes simplex virus ◯ Yes ◯ No	Crohn disease and ulcerative colitis ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No	Emphysema/Lung Disease ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No
Fainting Spells/Dizzines ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Gastroesophageal reflux disease (GERD) ◯ Yes ◯ No	Genital Herpes/HPV ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Heart attack/Failure ◯ Yes ◯ No
Hemophilia/Excessive Bleeding ◯ Yes ◯ No	Hepatitis A or B ◯ Yes ◯ No	Hepatitis C ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No
High Cholesterol ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Osteoporosis (Porous bone) ◯ Yes ◯ No	Pacemaker/Watchmen device ◯ Yes ◯ No
Pain in Jaw Joints ◯ Yes ◯ No	Parathyroid Disease/Thyroid Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Renal Dialysis/Kidneys disease ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Sickle Cell Disease ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Swelling of Limbs ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Venereal Disease ◯ Yes ◯ No			

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Emergency Contact: Please list name and phone number	☐	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.
(Sign at X mark)

Signature of Patient, Parent or Guardian:

X Date:_____