MEDICAL HISTORY

Today's Date: ____/____/20____ Patient Name: _____

Patient's DOB: ____/ ____/ 20___ Patient's BP: _____/_____

Are you under physician's care now?	❑Yes ❑No	Do you use tobacco?	❑Yes ❑No
Have you ever been hospitalized or had major operation?	❑Yes ❑No	Do you use controlled substances?	❑Yes ❑No
Have you taken any bisphosphonates?	❑Yes ❑No	***Woman Only:***	
Are you taking any medications, pills, or drugs?	❑Yes ❑No	Are you pregnant or trying to get pregnant?	❑Yes ❑No
Do you take, or have you taken, Phen-Fen or Redux?	❑Yes ❑No	Are you taking any oral contraceptives?	❑Yes ❑No
Are you on a special diet?	❑Yes ❑No	Are you nursing?	❑Yes ❑No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa Drugs ❑ Other

If yes, please explain:

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

AIDS/HIV Positive	❑ Yes	❑ No	Leukemia	❑ Yes	❑ No
Cortisone Medicine	❑ Yes	❑ No	Blood Transfusion	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No	Frequent Diarrhea	❑ Yes	❑ No
Renal Dialysis	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No
Alzheimer's Disease	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Breathing Disease	❑ Yes	❑ No
Hepatitis A	❑ Yes	❑ No	Frequent Headaches	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No
Anaphylaxis	❑ Yes	❑ No	Swelling of Limbs	❑ Yes	❑ No
Drug Addiction	❑ Yes	❑ No	Bruise Easily	❑ Yes	❑ No
Hepatitis B and C	❑ Yes	❑ No	Genital Herpes	❑ Yes	❑ No
Rheumatism	❑ Yes	❑ No	Lung Disease	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Thyroid Disease/Problems	❑ Yes	❑ No
Easily Winded	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Herpes	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No
Angina Pectoris	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Chemotherapy	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Hay Fever	❑ Yes	❑ No
Shingles	❑ Yes	❑ No	Pain in Jaw Joints	❑ Yes	❑ No
Arthritis/Gout	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Epilepsy or Seizure	❑ Yes	❑ No	Chest Pains	❑ Yes	❑ No
Allergies, Hives or Rash	❑ Yes	❑ No	Heart Attack/Failure	❑ Yes	❑ No
Sickle Cell Disease	❑ Yes	❑ No	Parathyroid Disease	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Tumors or Growths	❑ Yes	❑ No
Excessive Bleeding	❑ Yes	❑ No	Cold Sores/Fever Blisters	❑ Yes	❑ No
Hypoglycemia	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Artificial Joint	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Excessive Thirst	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No	Congenital Heart Disorder	❑ Yes	❑ No
Spina Bifida	❑ Yes	❑ No	Heart Pacemaker	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Problems or Surgery	❑ Yes	❑ No
Fainting Spells/Dizziness	❑ Yes	❑ No	Convulsions	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No	Radiation Treatments	❑ Yes	❑ No
Stomach/Intestinal disease	❑ Yes	❑ No	Recent Weight Loss	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	Yellow Jaundice	❑ Yes	❑ No
Frequent or Chronic Cough	❑ Yes	❑ No	Arteriosclerosis	❑ Yes	❑ No

MEDICAL HISTORY

Have you ever had any serious illness not listed on the previous page? ❑Yes ❑No If yes, please explain:

List any Medication, Drugs or Pills that you are taking:

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____
5. _____ Dose: _____
6. _____ Dose: _____

Are you taking: ❑ Blood Thinner (Coumadin/Plavix/Other) ❑ Immunosuppressant

Have you been a patient in the hospital during the past two years? ❑ Yes ❑ No For what?

Have you had Orthopedic Surgery: ❑ Yes ❑ No Have you had Cosmetic Surgery: ❑ Yes ❑ No

Are you experiencing discomfort at this time? ❑ Yes ❑ No

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

Have you had head or neck radiation treatments? ❑ Yes ❑ No

Do you use more than two pillows to sleep? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Do you ever wake up from sleep and feel short of breath? ❑ Yes ❑ No

Have you lost or gained more than 10 pounds in the past year? ❑ Yes ❑ No

Has your medical doctor ever said you have a cancer or tumor? ❑ Yes ❑ No

Name of medical doctor: Phone:

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner and that I have accurately answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to me (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I, hereby, authorize the dentist and staff to take x-rays, study models, photographs, or any other diagnostic aid as deemed appropriate by the dentist to make a thorough diagnosis of my or the Patient's dental needs. I also authorize the dentist to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my dental care.

Printed Name of Patient, Parent or Guardian:	
Patient, Parent or Guardian Printed Name:	**Date:**
Printed Name of Doctor:	
Doctor Signature:	**Date:**