

Medical History

First Name _____ Last Name _____ Birth Date _____ Date _____

Are you under the care of a physician? Yes No _____ If yes, explain below

Have you ever been hospitalized or had a major operation? Yes No _____ If yes, explain below

Have you ever had a serious head or neck injury? Yes No _____ If yes, explain below

Are you taking any medications, pills or drugs? Yes No _____ If yes, complete the medications section at the end

Do you take or have taken, Phen-Fen or Redux? Yes No _____ If yes, explain below

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____ If yes, explain below

Are you on a special diet? Yes No _____ If yes, explain below

Do you use tobacco? Yes No _____ If yes, explain below

Do you use controlled substances? Yes No _____ If yes, explain below

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment? Yes No _____ If yes, explain below

Women: Are You...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetic

Do you have or have you had any of the following diseases or medical conditions?

<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatments
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> <input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Easily Winded	<input type="checkbox"/> <input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Rheumatism
<input type="checkbox"/> <input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/> Hives or Rash	<input type="checkbox"/> <input type="checkbox"/> Shingles
<input type="checkbox"/> <input type="checkbox"/> Artificial Joint	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Frequent Cough	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	<input type="checkbox"/> <input type="checkbox"/> Spina Bifida
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Leukemia	<input type="checkbox"/> <input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> <input type="checkbox"/> Breathing Problem	<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> <input type="checkbox"/> Genital Herpes	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Tonsilitis
<input type="checkbox"/> <input type="checkbox"/> Chest Pains	<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> <input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
			<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No _____
Comments _____

Medications

Please list any other medication(s) you are taking

Medication	Medication

Please list any allergies other than drug allergies:

Do you have any known allergies? Yes No

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

I consent to the diagnostic procedures and treatment by the dentist(s) of this office necessary for proper dental care.

Signature of patient (Parent or Guardian if Minor)

Date