Medical History

Patient ID #: __________ Patient Name: ________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following health related questions:

Please circle the appropriate answer. If YES please describe,

Are you currently under a physicians care? YES NO Physicians Name: ____________________________

Have you EVER been hospitalized or had major operation? YES NO ____________________________

Have you EVER had a serious head or neck injury? YES NO ____________________________

Are you currently taking ANY medication; prescribed or OTC? YES NO ____________________________

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Are you or have you ever taken Phen-Fen or Redux? YES NO ____________________________

Are you or have you ever taken Fosamax, Boniva, Actonel or any other Bisphosphonates? YES NO ____________________________

Do you use Tobacco? YES NO ____________________________

WOMEN: Are you pregnant or trying to get pregnant? YES NO

Are you nursing? YES NO

Are you taking oral contraceptives? YES NO

ALLERGIES

Circle ALL that may apply:

Are you allergic to any of the following medications:

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

Other not listed: ____

Do you have, or have your ever had any of the following? **CIRCLE ALL THAT APPLY:**

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

Have you ever had a serious illness not listed above? YES NO ____________________________

The above information is true and complete to the best of my knowledge. ____________ **Please Initial**

I certify by signing below that I have been given a copy of the office's Notice of Privacy Practices.

I certify that have read and understand the above. I acknowledge that my questions, if any about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient/ Guardian Signature: ____________________________

Date: ______________ **Staff Signature:** ____________________________

Dentist Signature: ____________________________