Medical History

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 have may have, or medication that you may be taking, could have an important interrelationship with dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ **DOB:** _____ **Date:**_____

Are you under a physician's care now? Yes / No If yes, _____

Are you taking any medications? Yes / No If yes, _____

Have you ever been hospitalized or had major operations? Yes / No If yes, _____

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

Have you ever had head and neck radiation? Yes / No If yes, _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? Yes / No If yes, _____

Do you use tobacco? Yes / No If yes, _____

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

Women: Are you...

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

Are you Allergic to the following?

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

O Other? If yes, _____

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

O Unrepaired Cyanotic (CHD) O Repaired CHD W/ Prosthetic Device O Transplantation Cardiac Valvulopathy

O Congenital Heart Disease

Do you have the Following?

AIDS/HIV Positive?	Yes / No	Kidney Problems	Yes / No	Previous Infective Endocarditis	
Alzhheimer's Disease	Yes / No	Liver Disease	Yes / No	(IE)	Yes / No
Anaphylaxis	Yes / No	Swelling Of Limbs	Yes / No	Recent Weight Loss	Yes / No
Anemia	Yes / No	Chemotherapy	Yes / No	Renal Dialysis	Yes / No
High Blood Pressure	Yes / No	Osteoporosis	Yes / No	Emphysema	Yes / No
High Cholesterol	Yes / No	Pain In Jaw Joints	Yes / No	Epilepsy or Seizures	Yes / No
Shingles	Yes / No	Ulcers	Yes / No	Hives or Rash	Yes / No
Asthma	Yes / No	Previous Clostridioides Difficile(C.Diff)		Sickle Cell Disease	Yes / No
Blood Disease	Yes / No		Yes / No	Sinus Trouble	Yes / No
Breathing Problems	Yes / No	Hemophilia	Yes / No	Leukemia	Yes / No
Low Blood Pressure	Yes / No	Hepatitis A	Yes / No	Bruise Easily	Yes / No
Thyroid Disease	Yes / No	Hepatitis B or C	Yes / No	Lung Disease	Yes / No
Heart Attack/Failure	Yes / No	Angina	Yes / No	Chest Pain	Yes / No
Heart Murmur	Yes / No	Arthritis/Gout	Yes / No	Cold Sores/Fever Blisters	Yes / No
Parathyroid Disease	Yes / No	Excessive Bleeding	Yes / No	Heart Pacemaker	Yes / No
Psychiatric Care	Yes / No	Hypoglycemia	Yes / No	Heart Trouble/Disease	Yes / No
Cortisone Medicine	Yes / No	Irregular Heartbeat	Yes / No	***Have you ever had any serious	
Diabetes	Yes / No	Spina Bifida	Yes / No	illness not listed above?	Yes / No
Drug Addiction	Yes / No	Stroke	Yes / No	If yes, _____	
Rheumatic Fever	Yes / No	Cancer	Yes / No	_____	
Rheumatism	Yes / No	Mitral Valve Prolapse	Yes / No	_____	
Artificial Heart Valve	Yes / No	Tuberculosis	Yes / No	_____	
Artificial Joint	Yes / No	Tumors or Growths	Yes / No		
Fainting Spells/Dizziness	Yes / No	Convulsions	Yes / No		

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

Signature of Patient, Parent or Guardian: _____ **Date:** _____