

Medical History

Name _____ Birthdate _____

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.

Are you under a physician's care now? Yes No

Physician's name: _____

Phone number: () _____

Do you take or have you recently taken any prescription? Yes No

If yes, list here: _____

Do you take or have you taken Phen-Fen or Redux? Yes No

Are you currently taking or are you scheduled to begin taking either alendronate (Fosamax) or risedronate (Actonel) for either osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biophosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date that said treatment began: _____

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

Have you had a serious illness, operation or been hospitalized any time in the past 5 years? Yes No

If yes, explain: _____

Do you currently have earaches or neck pain? Yes No

Do you have clicking, popping, or jaw discomfort? Yes No

Do you have sores or ulcers in your mouth? Yes No

Have you ever had a serious injury in your mouth? Yes No

Do you use controlled substances or illegal drugs? Yes No

Do you use tobacco (cigarettes, snuff, chew, bidis)? Yes No

Are you interested in stopping? Yes No

Do you drink alcoholic beverages? Yes No

If yes, how much did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Women only: Are you pregnant? Yes No # of Weeks: _____

Taking birth control pills or hormonal replacement? Yes No

Are you nursing? Yes No

Allergies - Are you allergic to or have you had a reaction to any of the following:

Local Anesthetics Yes No Animals Yes No Iodine Yes No Sulfa Drugs Yes No

Aspirin Yes No Metals Yes No Codeine Yes No Food Yes No

Penicillin Yes No Latex (Rubber) Yes No Sleeping Pills Yes No Other Yes No

Other: _____

Do you have or have you ever had any of the following:

Heart Murmur Yes No Mitral Valve Prolapse Yes No Artificial Heart Valves Yes No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

If yes, when (date): _____ Physician's Name: _____

Aids/HIV Positive Yes No Coronary Artery Disease Yes No Headaches/Migranes Yes No Low Blood Pressure Yes No

Alzheimer's Disease Yes No Damaged Heart Valves Yes No Heart Attack/Failure Yes No Lung Disease Yes No

Abnormal Bleeding Yes No Diabetes Yes No Heartburn Yes No Malnutrition Yes No

Anaphylaxis Yes No Drug Addiction Yes No Heart Pace Maker Yes No Mental Health Disorders Yes No

Anemia Yes No Easily Winded Yes No Heart Trouble/Disease Yes No Neurological Disorders Yes No

Angina Yes No Eating Disorder Yes No Hemophilia Yes No Osteoporosis Yes No

Arthritis/Gout Yes No Emphysema Yes No Hepatitis A Yes No Pace Maker Yes No

Artificial Joint(s) Yes No Epilepsy or Seizures Yes No Hepatitis B & C Yes No Radiation Treatment Yes No

Asthma Yes No Excessive Bleeding Yes No Herpes Yes No Recurrent Infections Yes No

Autoimmune Disease Yes No Excessive Thirst Yes No High Blood Pressure Yes No Rheumatoid Arthritis Yes No

Blood Transfusion Yes No Excessive Urination Yes No Hives or Rash Yes No Scarlet Fever Yes No

Blood Disease Yes No Fainting/Dizziness Yes No Hypoglycemia Yes No Shingles Yes No

Bruise Easily Yes No Frequent Cough Yes No Irregular Heart Beat Yes No Sinus Trouble Yes No

Cancer Yes No Gastrointestinal Disease Yes No Kidney Problems Yes No Tonsillitis Yes No

Cardiovascular Disease Yes No Glaucoma Yes No Lukemia Yes No Tuberculosis Yes No

Congenital Heart Disorder Yes No Hay Fever Yes No Liver Disease Yes No Ulcers Yes No

Convulsions Yes No Comments: _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature (Patient, Parent or Guardian): _____ Date: _____

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