## **MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_\_ Birth Date \_\_\_\_\_

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.

Have you ever been hospitalized or ha Have you ever had a serious Are you taking any medicat Do you take, or have you taken, I Have you ever taken Fosamax, B other medications containin Are you	head or neck injury? ions, pills, or drugs? Phen-Fen or Redux? poniva, Actonel or any g bisphosphonates? pu on a special diet? o you use tobacco? htrolled substances?	Yes No If Yes No If Yes No If Yes No Yes No Yes No Yes No Yes No	yes, please explain: yes, please explain: yes, please explain: yes, please explain:			
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No						
Are you allergic to any of the followin Aspirin Penicillin Other If yes, please explain:	<u> </u>	ocal Anesthetics	Acrylic	Metal	Latex	Sulfa drugs
Do you have, or have you had, any of AIDS/HIV Positive       Yes       No         AIDS/HIV Positive       Yes       No         Alzheimer's Disease       Yes       No         Anaphylaxis       Yes       No         Anemia       Yes       No         Angina       Yes       No         Antrificial Heart Valve       Yes       No         Artificial Joint       Yes       No         Asthma       Yes       No         Blood Disease       Yes       No         Blood Transfusion       Yes       No         Bruise Easily       Yes       No         Cancer       Yes       No         Chemotherapy       Yes       No         Concer       Yes       No         Cond Sores/Fever Blisters       Yes       No         Convulsions       Yes       No         Have you ever had any serious illne       Comments:	Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease	<ul> <li>Yes</li> <li>No</li> </ul>	Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints	Yes       No         Yes       No	Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Di Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice	Yes         No           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.