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.

Are you under a physician's care now? Yes No If yes, please explain:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No Are you on a special diet? Yes No Do you use tobacco? Yes No	
Do you use controlled substances? Yes No Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No	Nursing? O Yes O No
Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Other If yes, please explain:	Metal Latex Sulfa drugs
Alzheimer's DiseaseYesNoDiabetesYesNoHepatitis AYAnaphylaxisYesNoDrug AddictionYesNoHepatitis AYAnemiaYesNoDrug AddictionYesNoHepatitis B or CYAnginaYesNoEasily WindedYesNoHerpesYArthritis/GoutYesNoEmphysemaYesNoHigh Blood PressureYArtificial Heart ValveYesNoExcessive BleedingYesNoHives or RashYArtificial JointYesNoExcessive ThirstYesNoHives or RashYAsthmaYesNoFrequent CoughYesNoIrregular HeartbeatYoBlood DiseaseYesNoFrequent DiarrheaYesNoLeukemiaYoBreathing ProblemYesNoGenital HerpesYesNoLow Blood PressureYoBruise EasilyYesNoGlaucomaYesNoLow Blood PressureYoChemotherapyYesNoHay FeverYesNoLung DiseaseYoCold Sores/Fever BlistersYesNoHeart MurmurYesNoParathyroid DiseaseYoCongenital Heart DisorderYesNoHeart PacemakerYesNoParathyroid DiseaseYo	Yes No Radiation Treatments Yes No Yes No Recent Weight Loss Yes No Yes No Renal Dialysis Yes No Yes No Renal Dialysis Yes No Yes No Rheumatic Fever Yes No Yes No Rheumatism Yes No Yes No Scarlet Fever Yes No Yes No Scarlet Fever Yes No Yes No Scickle Cell Disease Yes No Yes No Sinus Trouble Yes No Yes No Stomach/Intestinal Disease Yes No Yes No Stroke Yes No Yes No Swelling of Limbs Yes No Yes No Tuberculosis Yes No Yes No Tuberculosis Yes No Yes No Venereal Disease Yes No Yellow Jaundice Y

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.