Medical History Form

Patient Name:_____ Birth Date:_____

Are you under a physician's care now? ○ Yes ○ No
If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No

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

Are you taking any medications, pills, or drugs? ○ Yes ○ No
Please List:

_____

Have you ever taken Fosamax, Boniva, Actonel,
or any other medications containing bisphosphonates? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No
Please List:

_____

Are you allergic to any of the following?

☐ Aspirin, Ibuprophen, Acetaminophen	☐ Codeine	☐ Tetracycline	☐ Fluoride
	☐Penicillin/Amoxicillin	☐ Sulfa Drugs	☐ Metal
	☐ Erythromycin	☐ Local Anesthetic	☐ Latex

☐ Other? _____

Women: Are you

☐ **Pregnant/Trying to get pregnant** ☐ **Nursing** ☐ **Taking Oral Contraceptives**

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

☐ AIDS/HIV Positive	☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Convulsions	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints
☐ Anaphylaxis	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Anemia	☐ Diabetes	☐ Hepatitis A	☐ Renal Dialysis
☐ Angina	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Arthritis/Gout	☐ Emphysema	☐ Herpes	☐ Shingles
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Sinus Trouble
☐ Artificial Joint	☐ Excessive Bleeding	☐ High Cholesterol	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Excessive Thirst	☐ Hives or Rash	☐ Stroke
☐ Blood Disease	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Tuberculosis
☐ Blood Transfusion	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Tumors or Growths
☐ Breathing Problems	☐ Frequent Headaches	☐ Kidney Problems	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Leukemia	☐ Ulcers
☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Venereal Disease
☐ Chemotherapy	☐ Hay Fever	☐Low Blood Pressure	
☐ Chest Pains	☐ Heart Attack/Failure	☐ Lung Disease	
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Mitral Valve Prolapse	

Have you ever had any serious illness not listed above? If yes, please explain:

_____

_____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. 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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

_____ Today's Date:_____