

Medical History Form

Patient Name _____ Birth Date _____

Physician's Name _____ Address _____ Phone _____

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?

- | | | | |
|--|---|---|-----------------------------------|
| <input type="checkbox"/> Aspirin, Ibuprophen,
Acetaminophen | <input type="checkbox"/> Codeine | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Fluoride |
| | <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Metal |
| | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Latex |

Other? _____

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

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

Women: Are you

- Pregnant/Trying to get pregnant Nursing Taking Oral Contraceptives

Have you ever had any condition or 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: _____