Aloha Stadium Dental Associates
Taking care of your smile

Medical History Form

Patient Name_____ Birth Date _____

Physician's Name_____ Physician's Address _____ Physician's Phone _____

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

Have you EVER been hospitalized or had an operation? ○ Yes ○ No
If yes, please explain:_____

Have you ever had a face, jaw, head, neck, or spinal injury? ○ Yes ○ No

Are you taking any medications, blood thinners, or supplements (prescribed or over the counter)? ○ Yes ○ No
Please List:

_____

Are you or have you been required or recommended to take antibiotics prior to dental treatment? ○ Yes ○ No

Have you ever taken Fosamax, Boniva, Actonel, Prolia, osteoporosis/bone medication, or anything containing bisphosphonates? ○ Yes ○ No

Do you use tobacco or vape? ○ Yes ○ No

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

_____

Do you have any special needs? (i.e. caretaker assistance, handicap access, etc.) ○ Yes ○ No
Please explain:

_____

Are you allergic to any of the following?

☐Aspirin	☐Ibuprofen	☐Penicillin/Amoxicillin	☐Other?
☐Acetaminophen	☐Latex	☐Other antibiotics	_____
☐Codeine	☐Metal	☐Sulfa Drugs	_____

Do you or have you had any of the following?

ADHD	○ Yes	○ No	CPAP Machine	○ Yes	○ No
AIDS/HIV Positive	○ Yes	○ No	Diabetes	○ Yes	○ No
Alzheimer's Disease/Dementia	○ Yes	○ No	Drug Addiction	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	Dry Mouth	○ Yes	○ No
Anemia	○ Yes	○ No	Emphysema	○ Yes	○ No
Angina	○ Yes	○ No	Epilepsy or Seizures	○ Yes	○ No
Aneurism	○ Yes	○ No	Excessive Bleeding	○ Yes	○ No
Arthritis/Gout	○ Yes	○ No	Excessive Thirst	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	Fainting Spells/Dizziness	○ Yes	○ No
Asthma	○ Yes	○ No	Frequent Cough	○ Yes	○ No
Blood Disease	○ Yes	○ No	Frequent Headaches	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	Glaucoma	○ Yes	○ No
Breathing Problems	○ Yes	○ No	Hay Fever	○ Yes	○ No
Bruise Easily	○ Yes	○ No	Heart Attack/Failure	○ Yes	○ No
Cancer	○ Yes	○ No	Heart Murmur	○ Yes	○ No
Chemotherapy	○ Yes	○ No	Heart Pacemaker	○ Yes	○ No
Chest Pains	○ Yes	○ No	Heart Trouble/Disease	○ Yes	○ No
Cold Sores/Fever Blisters	○ Yes	○ No	Hemophilia	○ Yes	○ No
Congenital Heart Disorder	○ Yes	○ No	Hearing Loss	○ Yes	○ No
Cortisone Medicine or Steroids	○ Yes	○ No			

Hepatitis A	○ Yes	○ No
Hepatitis B or C	○ Yes	○ No
Herpes	○ Yes	○ No
High Blood Pressure	○ Yes	○ No
High Cholesterol	○ Yes	○ No
Hives or Rash	○ Yes	○ No
Hypoglycemia	○ Yes	○ No
Irregular Heartbeat	○ Yes	○ No
Joint replacement	○ Yes	○ No
Leukemia	○ Yes	○ No
Liver Disease	○ Yes	○ No
Long COVID	○ Yes	○ No
Low Blood Pressure	○ Yes	○ No
Lung Disease	○ Yes	○ No
Mitral Valve Prolapse	○ Yes	○ No
Organ transplant	○ Yes	○ No
Osteoporosis	○ Yes	○ No
Pain in Jaw Joints	○ Yes	○ No
Psychiatric Care	○ Yes	○ No
Radiation Treatments	○ Yes	○ No
Recent Weight Loss	○ Yes	○ No
Renal Dialysis	○ Yes	○ No
Rheumatic Fever	○ Yes	○ No
Shingles	○ Yes	○ No
Sinus Trouble	○ Yes	○ No
Sjogren's Syndrome	○ Yes	○ No
Sleep Study	○ Yes	○ No
Snoring or Sleep Apnea	○ Yes	○ No
Spina Bifida	○ Yes	○ No
Stent	○ Yes	○ No
Stomach/Intestinal Disease	○ Yes	○ No
Stroke	○ Yes	○ No
Tuberculosis	○ Yes	○ No
Tumors or Growths	○ Yes	○ No
Thyroid Disease	○ Yes	○ No
Ulcers	○ Yes	○ No
Venereal Disease	○ Yes	○ No
Vertigo	○ Yes	○ No

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:_____