Leigh Family & Cosmetic Dentistry - Medical History Form

Revised 12/19

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.

Patient Name: ______________________ Date of Birth:______________ Date of Form Completion: ______________

Question			
Are you under a physician's care now?	Yes	No	If Yes ______________________
Have you ever been hospitalized or had a major operation?	Yes	No	If Yes ______________________
Have you ever had a serious head or neck injury?	Yes	No	If Yes ______________________
Are you taking any medications, pills, or drugs?	Yes	No	If Yes ______________________
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If Yes ______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonfates?	Yes	No	If Yes ______________________
Are you on a special diet?	Yes	No	If Yes ______________________
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	If Yes ______________________
Do you require a pre-medication for dental work?	Yes	No	
Have you had your third molars(wisdom) teeth removed?	Yes	No	
Have you had orthodontic treatment?	Yes	No	

Women: Are you…

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal

Latex Sulfa Drugs Local Anesthetics Other? ______________________

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

	AIDS / HIV Positive		Cortisone Medication		Hemophilia		Radiation Treatments
	Alzheimer’s Disease		Diabetes		Hepatitis A		Recent Weight Loss
	Anaphylaxis		Drug Addition		Hepatitis B or C		Renal Dialysis
	Anemia		Easily Winded		Herpes		Rheumatic Fever
	Angina		Emphysema		High Blood Pressure		Rheumatism
	Arthritis / Gout		Epilepsy or Seizures		High Cholesterol		Scarlet Fever
	Artificial Heart Valve		Excessive Bleeding		Hives or Rash		Shingles
	Artificial Joint		Excessive Thirst		Hypoglycemia		Sickle Cell Disease
	Asthma		Fainting Spells / Dizziness		Irregular Heartbeat		Sinus Trouble
	Blood Disease		Cough (persistent)		Kidney Problems		Spina Bifida
	Bood Transfusion		Leukemia		Stomach / Intestinal Disease		Breathing Problems
	Frequent Headaches		Liver Disease		Stroke		Bruise Easily
	Genital Herpes		Low Blood Pressure		Swelling of Limbs		Cancer
	Glaucoma		Lung Disease		Thyroid Disease		Chemotherapy
	Hay Fever		Mitral Value Prolapse		Tonsilitis		Chest Pains
	Heart Attack / Failure		Osteoporosis		Tuberculosis		Cold Sores / Fever Blisters
	Heart Murmur		Pain in Jaw Joints		Tumors or Growths		Congenital Heart Disorder
	Heart Pacemaker		Parathyroid Disease		Ulcers		Convulsions
	Heart Trouble / Disease		Psychiatric Care		Venereal Disease		Yellow Jaundice
	Autoimmune Disease		Snoring		Sleep Apnea		TMJ
	Clenching / Grinding		Cognitive or sensory issues				

Have you ever had any serious illness not listed above? Yes No If Yes ______________________

Additional comments on the back of medical history? 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.

Signature of Patient, Parent or Guardian: ______________________ Date: ______________