Brian D. Sass, DMD PC

Medical History

Patient Name: Birth Date: Date Created:

Health problems that you may have, or medication that you may be taking, could have an interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Primary Care Physician (Name, Phone)	Yes / No	If yes
Specialty Care Physician (Name, Phone)	Yes / No	If yes
Have you been hospitalized or had a major operation in the past 5 years?	Yes / No	If yes
Have you had a serious head or neck injury in the past 5 years?	Yes / No	If yes
Are you taking any medications, pills, drugs, vitamins or supplements?	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 bisphosphonates?	Yes / No	If yes
Are you on a special diet?	Yes / No	If yes
Do you use tobacco?	Yes / No	If yes
Do you use marijuana?	Yes / No	If yes
Do you use controlled substances?	Yes / No	If yes

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
☐ Erythromycin	☐ Epinephrine	☐ NSAID	

Other? Yes / No If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes / No	Cortisone Medicine	Yes / No	Hemophilia	Yes / No	Radiation Treatments	Yes / No
Alzheimer's Disease	Yes / No	Diabetes	Yes / No	Hepatitis A	Yes / No	Recent Weight Loss	Yes / No
Anaphylaxis	Yes / No	Drug Addiction	Yes / No	Hepatitis B or C	Yes / No	Renal Dialysis	Yes / No
Anemia	Yes / No	Easily Winded	Yes / No	Herpes	Yes / No	Rheumatic Fever	Yes / No
Angina	Yes / No	Emphysema	Yes / No	High Blood Pressure	Yes / No	Rheumatism	Yes / No
Arthritis/Gout	Yes / No	Epilepsy or Seizures	Yes / No	High Cholesterol	Yes / No	Scarlet Fever	Yes / No
Artificial Heart Valve	Yes / No	Excessive Bleeding	Yes / No	Hives or Rash	Yes / No	Shingles	Yes / No
Artificial Joint	Yes / No	Excessive Thirst	Yes / No	Hypoglycemia	Yes / No	Sickle Cell Disease	Yes / No
Asthma	Yes / No	Fainting Spells/Dizziness	Yes / No	Irregular Heartbeat	Yes / No	Sinus Trouble	Yes / No
Blood Disease	Yes / No	Frequent Cough	Yes / No	Kidney Problems	Yes / No	Spina Bifida	Yes / No
Blood Transfusion	Yes / No	Frequent Diarrhea	Yes / No	Leukemia	Yes / No	Stomach/Intestinal Disease	Yes / No
Breathing Problems	Yes / No	Frequent Headaches	Yes / No	Liver Disease	Yes / No	Stroke	Yes / No
Bruise Easily	Yes / No	Genital Herpes	Yes / No	Low Blood Pressure	Yes / No	Swelling of Limbs	Yes / No
Cancer	Yes / No	Glaucoma	Yes / No	Lung Disease	Yes / No	Thyroid Disease	Yes / No
Chemotherapy	Yes / No	Hay Fever	Yes / No	Mitral Valve Prolapse	Yes / No	Tonsillitis	Yes / No
Chest Pains	Yes / No	Heart Attack/Failure	Yes / No	Osteoporosis	Yes / No	Tuberculosis	Yes / No
Cold Sores/Fever Blisters	Yes / No	Heart Murmur	Yes / No	Pain in Jaw Joints	Yes / No	Tumors or Growths	Yes / No
Congenital Heart Disorder	Yes / No	Heart Pacemaker	Yes / No	Parathyroid Disease	Yes / No	Ulcers	Yes / No
Convulsions	Yes / No	Heart Trouble/Disease	Yes / No	Psychiatric Care	Yes / No	Venereal Disease	Yes / No
Yellow Jaundice	Yes / No						

Question	Answer	
Please give the date(s) first diagnosed with any conditions marked above.	Yes / No	If yes
Have you ever had any serious illness not listed above?	Yes / No	If yes

Additional Comments:

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:

X Date:__________