MEDICAL HISTORY

PATIENT NAME ____ Birth Date ________________

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of your primary physician. ____
Have you ever had a major operation? __Yes __ No If yes, please explain: _____________________________________
____
Have you ever had a serious head or neck injury? __ Yes __ No If yes, please explain: ____________________________
Have you ever taken Fosamax, Boniva, Actonel, or other osteoporosis medications? __ Yes __ No __________________
Are you taking any medications, pills, or vitamins? Please list: ____
____
____

Please list any allergies that you may have. Penicillin, Codeine, Latex, Sulfa Drugs, etc. ___________________________
____

Do you have, or have you ever had any of the following? Please check

___ AIDS/HIV Positive
___ Alzheimer's Disease
___ Anaphylaxis
___ Arthritis/Gout
___ Artificial Heart Valve
___ Joint Replacement
  ___ Hip
  ___ Knee
  ___ Other
  Date of Surgery ______
___ Cancer
  What Type?
  ____
___ Chemotherapy
  Date of Last tx. ______
___ Radiation
  Date of Last tx. ______
___ Cold Sores or Fever Blisters
___ Congenital Heart Disorder
___ Cortisone Medicine

___ Coumadin or Blood Thinners
___ Diabetes
___ Drug Addiction
___ Epilepsy or Seizures
___ Excessive Bleeding
___ Fainting Spells/Dizziness
___ Frequent Headaches
___ Heart Disease or Condition
  ___ Heart Murmur
  ___ Pacemaker
  ___ Mitral Valve Prolapse
  ___ Stent
___ Hepatitis
___ A___B___C___D___
___ High Blood Pressure
___ Hypoglycemia
___ Kidney Disease
  What Type?
  ____
___ Leukemia
___ Low Blood Pressure

___ Lung Disease
___ Osteoporosis
___ Pregnant
  Due Date _________
___ Psychiatric Care
___ Renal Dialysis
___ Shingles
___ Sinus Trouble
___ Stroke
___ Thyroid Disease
___ Tobacco Use
___ Tuberculosis
___ Tumors or Growths
___ Ulcers
  ___ Mouth
  ___ Stomach

Do you have any disease, condition, or problem not listed above?
____
____

Dental History

When was your last dental visit? __________ What was done? ____
Have you ever been referred to a Periodontist (Gum Specialist)? ___ Yes ___ No
Do you clinch or grind your teeth while awake or in your sleep? ___ Yes ___ No
Are your teeth sensitive to heat, cold, sweets, or biting pressure? If so, please explain: _________________________
____

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