MEDICAL HEALTH HISTORY

Patient Name: Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you 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.

Question	Yes	No	If yes
Are you under a physician's care now?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Do you pre-medicate before procedures?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Do you use tobacco?	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
- [ ] CODIENE
- [ ] ACRYLIC
- [ ] METAL
- [ ] LATEX
- [ ] SULFA DRUGS
- [ ] EPINEPHRINE

Question	Yes	No	If yes
Do you have any other allergies to medications or anything else?	Yes	No	If yes
Do you have a drug addiction or use controlled substances?	☐		If yes

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
HIGH BLOOD PRESSURE	Yes	No	HEPATITIS	Yes	No	CANCER	Yes	No	SINUS	Yes	No
LOW BLOOD PRESSURE	Yes	No	HEMOPHILIA	Yes	No	RADIATION	Yes	No	HAY FEVER	Yes	No
MITRAL VALVE PROLAPSE	Yes	No	BLOOD DISEASE	Yes	No	CHEMOTHERAPY	Yes	No	ASTHMA	Yes	No
ANGINA	Yes	No	BLOOD TRANSFUSION	Yes	No	LEUKEMIA	Yes	No	LUNG DISEASE	Yes	No
CHEST PAIN	Yes	No	ANEMIA	Yes	No	TUMORS/GROWTHS	Yes	No	FREQUENT COUGH	Yes	No
HEART DISEASE	Yes	No	BRUISE EASILY	Yes	No	ARTHRITIS/GOUT	Yes	No	EMPHYSEMA	Yes	No
HEART MURMUR	Yes	No	EXCESSIVE BLEEDING	Yes	No	ARTIFICIAL JOINT	Yes	No	EASILY WINDED	Yes	No
HEART ATTACK/FAILURE	Yes	No	DIABETES	Yes	No	CORTISONE	Yes	No	ANAPHYLAXIS	Yes	No
ARTIFICIAL HEART VALVE	Yes	No	HYPOGLYCEMIA	Yes	No	OSTEOPOROSIS	Yes	No	TUBERCULOSIS	Yes	No
HEART PACEMAKER	Yes	No	EXCESSIVE THIRST	Yes	No	PAIN IN JAW JOINT	Yes	No	THYROID DISEASE	Yes	No
CON HEART DISORDER	Yes	No	STROKE	Yes	No	VENEREAL DISEASE	Yes	No	PARATHYROID DISEASE	Yes	No
IRREGULAR HEART BEAT	Yes	No	EPILEPSY/SIEZURES	Yes	No	AIDS/HIV POSITIVE	Yes	No	RHEUMATIC FEVER	Yes	No
HIGH CHOLESTEROL	Yes	No	CONVULSIONS	Yes	No	HERPES	Yes	No	SCARLET FEVER	Yes	No
KIDNEY DISEASE	Yes	No	FAINTING/DIZZY	Yes	No	HIVES / RASH	Yes	No	ALZHEIMERS	Yes	No
RENAL DIALYSIS	Yes	No	ULCERS	Yes	No	SHINGLES	Yes	No	PSYCHIATRIC CARE	Yes	No
LIVER DISEASE	Yes	No	STOMACH/INTESTINAL	Yes	No	COLD SORES	Yes	No	IMMUNE ISSUES	Yes	No
SWELLING OF LIMBS	Yes	No	ACID REFLUX	Yes	No	GENITAL HERPES	Yes	No	TRANSPLANTED ORGANS	Yes	No

Question	Yes	No	If yes
Have you ever had any serious illness not listed above?	Yes	No	If yes
Is there anything we need to know about you?	Yes	No	If yes
OFFICE NOTES:	Yes	No	If yes

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:__________