Medical History and Information

Patient Name________________________________ Date of Birth________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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.

- Primary Medical Doctor____________________________ Date and Reason of last visit___________________________________
- Are you under a physician's care now? Y N If yes, explain: ____
- Have you ever been hospitalized or had a major operation? Y N If yes, explain: ____
- Are you taking any medication, pills, or drugs? Y N If
- Do you take or have you taken Phen-Fe or Redux? Y N If yes, explain: ____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y N If yes, please list dose, frequency, duration____
- Are you on a special diet? Y N If yes, explain: ____
- Do you use tobacco? Y N
- Do you use controlled substances? Y N If yes, please list: ____
- (Women) Are you pregnant? Y N If yes, please list due date: ____
- Do you currently wear a retainer or night guard? Y N
- Are you currently taking any blood thinning medications? (Coumadin, Warfarin, Plavix, Aspirin, etc.) ________________________
- Are you allergic to any of the following? If yes, please check and explain reaction:
- ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
- Other Known Allergies (including other medications not listed): ____

Please circle Yes (Y) or No (N) along with the date if you have or have ever had any of the following:

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

Any current or history of other condition not listed above: ____

Please list all current medications and dosages: ____

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I have answered the above health history questions truthfully and to the best of my knowledge. I understand this information is important in order to receive dental care in the safest possible manner.

Signature____Date_____________________________

Comments:

Doctor's Signature____Date____________________________