# Dental/Medical History

Patient Name: Birth Date: Date Created:

Are you under a physician's care now? If yes, please include name and phone number: ◯ Yes ◯ No If yes

Have you ever been hospitalized, had a major operation or had a serious head or neck injury? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs? If yes, please list below. ◯ Yes ◯ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Do you require premedication for your dental visits? If yes, please list medication and dose. ◯ 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
☐ Tetracyclin

Other allergies? ☐ If yes

Do you use any recreational drugs? ◯ Yes ◯ No If yes

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

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| 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 ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No | Anemia ◯ Yes ◯ No |
| Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No | Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No |
| High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No | Arthritis/Rheumatism ◯ 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 | Low Blood Pressure ◯ Yes ◯ No |
| Swelling of Limbs/Gout ◯ Yes ◯ No | Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No |
| Thyroid Disease ◯ Yes ◯ No | Chemotherapy ◯ Yes ◯ No | Tobacco Use ◯ 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 | TMJ or jaw pain ◯ 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 |

Have you ever had any serious illness not listed ◯ 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:_____