MEDICAL HISTORY

Please check YES or NO for each history question.

Are you under a physician's care now? ☐ YES ☐ NO if yes, please explain _____

Have you ever been hospitalized? ☐ YES ☐ NO if yes, please explain _____

Have you ever had a major operation? ☐ YES ☐ NO if yes, please explain _____

Are you taking any medications, pills, drugs? ☐ YES ☐ NO if yes, please explain _____

Have you ever taken Phen-Fen or Redux? ☐ YES ☐ NO if yes, please explain _____

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing Bisphosphonates? ☐ YES ☐ NO if yes, please explain _____

Have you ever had a serious head/neck injury? ☐ YES ☐ NO if yes, please explain _____

Are you on a special diet? ☐ YES ☐ NO if yes, please explain _____

Do you use tobacco? ☐ YES ☐ NO if yes, please explain _____

Do you use controlled substances? ☐ YES ☐ NO if yes, please explain _____

Women: Are you

Pregnant / Trying to get pregnant? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Are you allergic to any of the following? (please circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other:

Do you have, or have you ever had any of the followig:

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

Have you ever had any serious illness not mentioned here? Explain : _____

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 GUARDINAN _____ **DATE:** _____