## **MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_\_ Birth Date \_\_\_\_\_

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

Have you ever been hospitalized or had Have you ever had a serious he Are you taking any medication Do you take, or have you taken, Ph Have you ever taken Fosamax, Bon other medications containing Are you Do	ad or neck injury? Yes ns, pills, or drugs? Yes en-Fen or Redux? Yes iva, Actonel or any Yes on a special diet? Yes you use tobacco? Yes olled substances? Yes	No       If yes, please ex         No	plain:		
Are you allergic to any of the following Aspirin Penicillin Other If yes, please explain:		Anesthetics	Acrylic 🗌 Metal	Latex	Sulfa drugs
Do you have, or have you had, any of         AIDS/HIV Positive       Yes       No         Alzheimer's Disease       Yes       No         Anaphylaxis       Yes       No         Anaphylaxis       Yes       No         Anaphylaxis       Yes       No         Anemia       Yes       No         Angina       Yes       No         Arthritis/Gout       Yes       No         Artificial Heart Valve       Yes       No         Artificial Joint       Yes       No         Asthma       Yes       No         Blood Disease       Yes       No         Blood Transfusion       Yes       No         Bruise Easily       Yes       No         Cancer       Yes       No         Chemotherapy       Yes       No         Cold Sores/Fever Blisters       Yes       No         Congenital Heart Disorder       Yes       No         Convulsions       Yes       No         Have you ever had any serious illness          Comments:	Cortisone Medicine       Y         Diabetes       Y         Drug Addiction       Y         Easily Winded       Y         Emphysema       Y         Epilepsy or Seizures       Y         Excessive Bleeding       Y         Excessive Thirst       Y         Fainting Spells/Dizziness       Y         Frequent Cough       Y         Frequent Headaches       Y         Glaucoma       Y         Hay Fever       Y         Heart Attack/Failure       Y         Heart Trouble/Disease       Y	Yes No Lung Disease     Yes No Mitral Valve Pr     Yes No Osteoporosis     Yes No Pain in Jaw Jo     Yes No Parathyroid Di     Yes No Psychiatric Ca	Yes       No       F         Yes       No       F         Yes       No       F         Passure       Yes       No       F         rol       Yes       No       S         Yes       No       S       S         Sease       Yes       No       S         Yes       No       S       S	Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Fonsillitis Fuberculosis Fumors or Growths JIcers /enereal Disease /ellow Jaundice	Yes       No         Yes       No

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.