Medical History

Patient Name:_____ **Date of Birth**:_____

Are you under a physician's care now? **O** Yes **O** No If yes:_____

Have you ever been hospitalized or had a major operation? O Yes O No If yes:_____

Have you ever had a serious head or neck injury? **O** Yes **O** No If yes:_____

Are you taking any medications, pills, or drugs? **O** Yes **O** No If yes:_____

Do you take or have you taken Phen-fen or Redux? **O** Yes **O** No If yes:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **O** Yes **O** No If yes:_____

Are you on a special diet? **O** Yes **O** No **Do you use tobacco?** **O** Yes **O** No

Women: Are you... **O** Pregnant/Trying to get pregnant? **O** Nursing? **O** Taking Oral Contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin **O** Codeine **O** Acrylic **O** Metal **O** Latex **O** Sulfa Drugs

O Local Anesthetics **O** Other? If yes:_____

O None of the above

Do you use controlled substances? O Yes O No If yes:_____

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

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 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 Heart Beat	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 Disorder	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	Venerial Disease	Y	N
									Yellow Jaundice	Y	N

Have you ever had any serious illness not listed? **O** Yes **O** No If yes:_____

_____

Please write in any other pertinent information that has not been covered.

_____

_____

Authorization: I hereby authorize the Doctor and/or team member of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears, on these medical and dental histories is correct to the best of my knowledge. I also authorize the doctor and/ or team member to contact my healthcare giver(s) concerning my treatment if necessary.

_____ _____

Patient/Parent/Guardian Signature **Date**