# Medical History Forms

Patient Name: Birth Date: Date Created:

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, c

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|---|---|---|
| Are you under a physician's care now? | ◯ Yes ◯ No | If yes |
| Have you been hospitalized or had a major operation in the last 5 years? | ◯ Yes ◯ No | If yes |
| Have you ever had a serious head or neck injury? | ◯ Yes ◯ No | If yes |
| Are you taking any medications, pills, or drugs? | ◯ Yes ◯ No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | ◯ Yes ◯ No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ◯ Yes ◯ No | If yes |
| Are you on a special diet? | ◯ Yes ◯ No | |
| Do you use tobacco? | ◯ Yes ◯ No | |
| Do you use controlled substances? | ◯ 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 |

Other? ☐ If yes

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ◯ Yes ◯ No | Cortisone Medicine | ◯ Yes ◯ No | Hemophilia | ◯ Yes ◯ No | Radiation Treatments | ◯ Yes ◯ No |
| Alzheimer's/Dementia | ◯ Yes ◯ No | Diabetes | ◯ Yes ◯ No | Hepatitis A | ◯ Yes ◯ No | Anaphylaxis | ◯ Yes ◯ No |
| Drug Addiction | ◯ Yes ◯ No | Hepatitis B or C | ◯ Yes ◯ No | Renal Dialysis | ◯ Yes ◯ No | Anemia | ◯ Yes ◯ No |
| Angina | ◯ Yes ◯ No | Emphysema/COPD | ◯ Yes ◯ No | High Blood Pressure | ◯ Yes ◯ No | Arthritis/Gout | ◯ Yes ◯ No |
| Epilepsy or Seizures | ◯ Yes ◯ No | High Cholesterol | ◯ Yes ◯ No | Artificial Heart Valve | ◯ Yes ◯ No | Excessive Bleeding | ◯ Yes ◯ No |
| Artificial Joint | ◯ Yes ◯ No | Hypoglycemia | ◯ Yes ◯ No | Asthma | ◯ Yes ◯ No | Irregular Heartbeat | ◯ Yes ◯ No |
| Sinus Trouble | ◯ Yes ◯ No | Blood Disease | ◯ Yes ◯ No | Blood Transfusion | ◯ Yes ◯ No | Leukemia | ◯ Yes ◯ No |
| Breathing Problems | ◯ Yes ◯ No | Frequent Headaches | ◯ Yes ◯ No | Liver Disease | ◯ Yes ◯ No | Stroke | ◯ Yes ◯ No |
| Low Blood Pressure | ◯ Yes ◯ No | Cancer | ◯ Yes ◯ No | Lung Disease | ◯ Yes ◯ No | Thyroid Disease | ◯ Yes ◯ No |
| Chemotherapy | ◯ Yes ◯ No | Seasonal Allergies | ◯ Yes ◯ No | Mitral Valve Prolapse | ◯ 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 | Pain in Jaw Joints | ◯ 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 | GERD | ◯ Yes ◯ No | Autoimmune Disorder | ◯ Yes ◯ No | Sleep Apnea | ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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 Guardian:

X Date:_____