

Medical History

Patient: _____

Birth Date: _____

Yes No

- Are you under a physician's care now? If yes: _____
- Have you been hospitalized or had a major operation? If yes: _____
- Have you ever had a serious head or neck injury? If yes: _____
- Are you taking any blood thinners, medications, pills, or drugs? If yes: _____

- Do you take, or have you taken, Phen-Fen or Rudex?
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
- Are you on a special diet?
- Do you use tobacco?
- Do you use controlled substances?

Women: Are you

Pregnant/trying to get pregnant?

Taking oral contraceptives?

Nursing?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs

Other: _____

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

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

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 or guardian: _____ Date: _____