Medical History

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	Yes / No	If yes	
Have you ever been hospitalized or had a major operation?	Yes / No	If yes	
Have you ever had a serious head or neck injury?	Yes / No	If yes	
Are you taking any medications, vitamins, or drugs?	Yes / No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates?	Yes / No	If yes	
Do you use tobacco? If yes, what type and how	Yes / No	If yes	
Are you pregnant? If yes, when is your due date?	Yes / No	If yes	

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics

Do you have any other allergies?	Yes / No	If yes	

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

Condition		Condition		Condition		Condition	
ADD or ADHD	Yes / No	Chemotherapy	Yes / No	Heart Pacemaker	Yes / No	Other Disease or Disorders**	Yes / No
Abnormal Bleeding	Yes / No	Cold Sores/Herpes	Yes / No	Heart Problems**	Yes / No	Radiation Treatment	Yes / No
AIDS/HIV	Yes / No	Diabetes	Yes / No	Hemophilia	Yes / No	Rheumatic Fever	Yes / No
Alzheimer's Disease	Yes / No	Drug Addiction	Yes / No	Hepatitis A, B, or C	Yes / No	Scarlet Fever	Yes / No
Anemia	Yes / No	Emphysema	Yes / No	High Blood Pressure	Yes / No	Sinus Trouble	Yes / No
Arthritis	Yes / No	Epilepsy/Seizures	Yes / No	Hypoglycemia	Yes / No	Sleep Disorder	Yes / No
Artificial Joint	Yes / No	Fainting/Dizziness	Yes / No	Kidney Problems	Yes / No	STDs	Yes / No
Asthma	Yes / No	Frequent Headaches	Yes / No	Liver Disease	Yes / No	Stroke	Yes / No
Autisim	Yes / No	GI Reflux	Yes / No	Lung Disease	Yes / No	Thyroid Disease	Yes / No
Blindness	Yes / No	Glaucoma	Yes / No	Osteoporosis	Yes / No	Tuberculosis	Yes / No
Cancer or Leukemia	Yes / No	Hearing Impaired	Yes / No				

**If you answered "Yes" to Heart Problems or Other Diseases or Disorders, describe condition:	Yes / No	If yes	

Question			
Have you had any problems associated with your previous dental treatments?	Yes / No	If yes	
Do your gums bleed when you brush or floss?	Yes / No	If yes	
Are your teeth sensitive to cold, hot, sweets or pressure?	Yes / No	If yes	
Does food or floss catch between your teeth?	Yes / No	If yes	
Do you suffer from dry mouth?	Yes / No	If yes	
Have you had periodontal (gum) disease treatments?	Yes / No	If yes	
Do you have popping or discomfort in your jaw?	Yes / No	If yes	
Do you brux or grind your teeth?	Yes / No	If yes	
Do you have sores or ulcers in your mouth?	Yes / No	If yes	
Do you like your smile?	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.

Signature of Patient, Parent or Guardian:

X Date:___________