MEDICAL HISTORY(Copy)(Copy)(Copy)

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.

MEDICAL HISTORY

Do you have a Primary Care Physician currently?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal

☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other_____

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Alzheimer's Disease ◯ 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	Herpes ◯ Yes ◯ No	Angina ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Cancer ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ 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	Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No		

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Do you have an autoimmune disease?	◯ Yes ◯ No	If yes

DENTAL HISTORY

Do you have a previous dentist? If yes, Please list Name and Date of Last Exam.	◯ Yes ◯ No	If yes
Do your gums bleed while brushing or flossing?	◯ Yes ◯ No	
Do you feel sensitivity or pain to any of your teeth?	◯ Yes ◯ No	
Do you wear dentures or partials? If yes, date of placement?	◯ Yes ◯ No	If yes

Comments:

This is to certify that I, undersigned, consent to the performing of the dental and oral procedures agreed to be necessary or advisable, including local anesthetic and diagnostic x-rays. I will assume responsibility for fees associated with these procedures, including any collection fee or court costs that may be incurred in collecting said fees. 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:_____