

# Medical History

**Patient Name** (please print) \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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 that you will be receiving. Thank you for answering the following questions.

|  | YES                      | NO                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1 Are you in good health?  | <input type="checkbox"/> | <input type="checkbox"/> | 9 Have you ever required a blood transfusion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Have there been any changes in your general health within the past year?   | <input type="checkbox"/> | <input type="checkbox"/> | 10 Have you ever taken Fen-Phen/Redux?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Date of your last physical exam _____  |                          |                          | 11 Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing Bisphosphonates?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Physicians Name _____<br>Phone # _____   |                          |                          | 12 Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Do you routinely see an MD?  | <input type="checkbox"/> | <input type="checkbox"/> | 13 Do you use tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Have you ever been hospitalized for any surgical operation or serious illness?<br>Please explain. _____<br>_____                                     | <input type="checkbox"/> | <input type="checkbox"/> | 14 Do you or have you use controlled substances in the last 12 hours?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Are you taking any medicine, including non-prescription medicine?<br>If yes, please provide a separate list or list here:<br>_____<br>_____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> | 15 Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Have you had any abnormal bleeding?  | <input type="checkbox"/> | <input type="checkbox"/> | 16 Do you have any disease, condition or problem not listed above that you think I should know about?                 | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | <b>Women only:</b>  |                          |                          |
|  |                          |                          | Are you pregnant or think you may be pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | Are you nursing?  | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | Are you taking birth control pills?   | <input type="checkbox"/> | <input type="checkbox"/> |

|  | YES                      | NO                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| <b>Are you allergic to or have you had reactions to:</b> |                          |                          | <b>Heart: Congestive Heart Failure</b>              | <input type="checkbox"/> | <input type="checkbox"/> |
| Local anesthetics like novocaine                         | <input type="checkbox"/> | <input type="checkbox"/> | Heart: Heart Attack, or Angina                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics                          | <input type="checkbox"/> | <input type="checkbox"/> | Heart: Mitral Valve Prolapse                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs  | <input type="checkbox"/> | <input type="checkbox"/> | Heart: Pacemaker                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin  | <input type="checkbox"/> | <input type="checkbox"/> | Heart: Rheumatic Heart Disease or Rheumatic Fever   | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine   | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B, Jaundice, Liver Disease or Hepatitis C | <input type="checkbox"/> | <input type="checkbox"/> |
| Any metals (e.g. - Nickel)                               | <input type="checkbox"/> | <input type="checkbox"/> | High/Low Blood Pressure                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex / Rubber   | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list) _____                                |                          |                          | Hives or Skin Rash                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Do you have or have you had the following:</b>        |                          |                          | Hypoglycemia (low blood sugar)                      | <input type="checkbox"/> | <input type="checkbox"/> |
| ADHD/Learning Disability                                 | <input type="checkbox"/> | <input type="checkbox"/> | IBS: Irritable Bowel Syndrome                       | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection                                    | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement: _____<br>Date of sx _____        | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies: Seasonal/Hay fever                            | <input type="checkbox"/> | <input type="checkbox"/> | Kidney issues                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia/Low iron  | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia  | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety: Dental (moderate to severe)                     | <input type="checkbox"/> | <input type="checkbox"/> | Lung Problems/Cancer                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety: General (moderate to severe)                    | <input type="checkbox"/> | <input type="checkbox"/> | Lupus   | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis  | <input type="checkbox"/> | <input type="checkbox"/> | Lyme Disease  | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma or breathing problems                             | <input type="checkbox"/> | <input type="checkbox"/> | Memory issues: _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Problems  | <input type="checkbox"/> | <input type="checkbox"/> | Mental health care                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer: _____  | <input type="checkbox"/> | <input type="checkbox"/> | Migraine headaches                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemical Dependency (past or current)                    | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis/Parkinsons                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy (cancer)                                    | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain   | <input type="checkbox"/> | <input type="checkbox"/> | Persistent Cough                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Sores   | <input type="checkbox"/> | <input type="checkbox"/> | Prostate issues/cancer                              | <input type="checkbox"/> | <input type="checkbox"/> |
| COPD   | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone treatments                                     | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough that produces blood or Tuberculosis (TB)           | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes/High Blood Sugar                                | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Dry mouth/Xerostomia/Sjogren's                           | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating disorders   | <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcer/Acid Reflux                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/seizures  | <input type="checkbox"/> | <input type="checkbox"/> | Stroke  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting or dizzy spells/vertigo                         | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of feet, ankles, or hands                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia   | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid issues                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart: Defect or heart murmur                            | <input type="checkbox"/> | <input type="checkbox"/> | Tumors  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart: Atrial fibrillation                               | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| Heart: Congenital Heart Problems                         | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

Patient Signature \_\_\_\_\_