Medical History

First Name | Last Name | Birth Date | Date

Are you under the care of a physician?	☐ Yes ☐ No	If yes, explain below
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, explain below
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, explain below
Are you taking any medications,pills or drugs?	☐ Yes ☐ No	If yes, complete the medications section at the end
Do you take or have taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes, explain below
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes, explain below
Are you on a special diet?	☐ Yes ☐ No	If yes, explain below
Do you use tobacco?	☐ Yes ☐ No	If yes, explain below
Do you use controlled substances?	☐ Yes ☐ No	If yes, explain below
Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment?	☐ Yes ☐ No	If yes, explain below

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 Anesthetic

Do you have or have you had any of the following diseases or medical conditions?

Y N	Y N	Y N	Y N
☐ ☐ AIDS/HIV Positive	☐ ☐ Cortisone Medicine	☐ ☐ Hemophilia	☐ ☐ Radiation Treatments
☐ ☐ Alzheimer's Disease	☐ ☐ Diabetes	☐ ☐ Hepatitis A	☐ ☐ Recent Weight Loss
☐ ☐ Anaphylaxis	☐ ☐ Drug Addiction	☐ ☐ Hepatitis B or C	☐ ☐ Renal Dialysis
☐ ☐ Anemia	☐ ☐ Easily Winded	☐ ☐ Herpes	☐ ☐ Rheumatic Fever
☐ ☐ Angina	☐ ☐ Emphysema	☐ ☐ High Blood Pressure	☐ ☐ Rheumatism
☐ ☐ Arthritis/Gout	☐ ☐ Epilepsy or Seizures	☐ ☐ High Cholesterol	☐ ☐ Scarlet Fever
☐ ☐ Artificial Heart Valve	☐ ☐ Excessive Bleeding	☐ ☐ Hives or Rash	☐ ☐ Shingles
☐ ☐ Artificial Joint	☐ ☐ Excessive Thirst	☐ ☐ Hypoglycemia	☐ ☐ Sickle Cell Disease
☐ ☐ Asthma	☐ ☐ Fainting Spells/Dizziness	☐ ☐ Irregular Heartbeat	☐ ☐ Sinus Trouble
☐ ☐ Blood Disease	☐ ☐ Frequent Cough	☐ ☐ Kidney Problems	☐ ☐ Spina Bifida
☐ ☐ Blood Transfusion	☐ ☐ Frequent Diarrhea	☐ ☐ Leukemia	☐ ☐ Stomach/Intestinal Disease
☐ ☐ Breathing Problem	☐ ☐ Frequent Headaches	☐ ☐ Liver Disease	☐ ☐ Stroke
☐ ☐ Bruise Easily	☐ ☐ Genital Herpes	☐ ☐ Low Blood Pressure	☐ ☐ Swelling of Limbs
☐ ☐ Cancer	☐ ☐ Glaucoma	☐ ☐ Lung Disease	☐ ☐ Thyroid Disease
☐ ☐ Chemotherapy	☐ ☐ Hay Fever	☐ ☐ Mitral Valve Prolapse	☐ ☐ Tonsilitis
☐ ☐ Chest Pains	☐ ☐ Heart Attack/Failure	☐ ☐ Osteoporosis	☐ ☐ Tuberculosis
☐ ☐ Cold Sores/Fever Blisters	☐ ☐ Heart Murmur	☐ ☐ Pain in Jaw Joints	☐ ☐ Tumors or Growths
☐ ☐ Congenital Heart Disorder	☐ ☐ Heart Pacemaker	☐ ☐ Parathyroid Disease	☐ ☐ Ulcers
☐ ☐ Convulsions	☐ ☐ Heart Trouble/Disease	☐ ☐ Psychiatric Care	☐ ☐ Venereal Disease
			☐ ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments

Medications

Please list any other medication(s) you are taking

Medication	Medication

Do you have any known allergies? ☐ Yes ☐ No

Please list any allergies other than drug allergies:

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

I consent to the diagnostic procedures and treatment by the dentist(s) of this office necessary for proper dental care.

Signature of patient (Parent or Guardian if Minor)

Date