

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

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.

- Are you under a physician's care now? Yes No DR'S NAME? _____
- Have you ever been hospitalized/or major surgery? Yes No WHY & DATE? _____
- Have you ever had a serious head or neck injury? Yes No WHAT & DATE? _____
- Are you taking any medications, pills, or drugs? Yes No **IF "YES" FILL OUT BACK OF SHEET**
- Do you take, or have you taken, Phen-Fen or Redux? Yes No
- Do you take, or have you taken bisphosphonates, such as Fosamax, Boniva, Actonel? Yes No
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No
- Women:** Are you Pregnant Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? CHECK FOR YES

- Aspirin Penicillin Amoxicillin Erythromycin Codeine Acrylic Metal Latex Local Anesthetics
- Sulfa Drugs Food Allergies Barbiturates, Sedatives, etc. Other _____

**** PLEASE CHECK ANY OF THE BELOW CONDITIONS YOU HAVE EVER HAD OR HAVE NOW.**

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

**** This condition may require you to be Pre-medicated. ****

Have you ever had any serious illness not listed above? Yes No N/A _____

I CURRENTLY WEAR PARTIALS OR DENTURES? TOP - _____ BOTTOM - _____

I HAVE BEEN WEARING PARTIALS OR DENTURES FOR _____ YEARS.

MY CURRENT DENTURES WERE MADE BY DR. _____.

HAVE YOU EVER HAD YOUR DENTURES RELINED? IF YES, WHEN? TOP - _____ BOTTOM - _____

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 in the future prior to treatment.

Signature of Patient, Parent, or Guardian

Date

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU ARE TAKING:

CARDIOVASCULAR MEDICATION

ASPIRIN
CALAN (VERAPAMIL)
DIGOXIN
INDERAL (PROPRANOLOL)
LASIX (FUROSEMIDE)
MIDAMOR (CHLOROTHIAZINE)
NITROGLYCERIN (NITROSTAT)
PROCARDIA XL (NIFEDIPINE)
ZESTRIL (LISINAPRIL)

ACCUPRIL (QUINAPRIL)
CORGARD (NADOLOL)
COUMADIN (WARFARIN)
LABETALOL
LOPRESSOR (METAPROLOL)
MONOPRIL (FOSINOPRIL)
PLAVIX
TENORMIN (ATENOLOL)

RESPIRATORY MEDICATION

AEROBID
ATROVENT
COMBIVENT
PROVENTIL
SEREVENT
VANCER

ADVAIR
AZMACORT
FLOVENT
PULMICORT
THEODUR (THEOPHYLLINE)
VENTOLIN (ALBUTEROL)

OSTEOPOROSIS MEDICATION

ACTONEL
FOSAMAX
RECLAST

BONIVA
MIRAPEX
REQUIP

ANXIETY / DEPRESSION MEDICATION

ATIVAN (LORAZEPAM)
CYMBALTA
EFFEXOR
LEXAPRO
XANAX
VALIUM

BUSPAR (BUSPIRONE)
PAXIL (PAROXETINE)
PROZAC (FLUOXETINE)
WELLBUTRIN (BUPROPION)
ZOLOFT

THYROID MEDICATION

LEVOTHYROXINE
SYNTHROID

LEVOXYL

CHOLESTEROL MEDICATION

CRESTOR
MEVACOR
TRICOR

LIPITOR
PRAVACHOL
ZOCOR

DIABETES MEDICATION

DIABETA
HUMULIN
GLUCOPHAGE (METFORMIN)

GLUCOTROL
WELCHOL

PAIN MEDICATION

LYRICA (PREGABALIN)
HYDROCODONE
MORPHINE
MOBIC (MELOXICAM)
TOPAMAX (TOPIRAMATE)
ULTRAM (TRAMADOL)
OXYCODONE

STERIOD MEDICATION

PREDNISONE
MEDROL DOSEPACK

ARTHRITIS MEDICATION

DOLOBID (DIFLUNISAL)
NALFON (FENOPROFEN)
VOLTAREN (DICLOFENAC)

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING AND NOT LISTED ABOVE.

NAME OF MEDICATION	WHY NEEDED	DOSAGE
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____