



Patient Name: _____

Date of Birth: _____

Date: _____

MEDICAL HISTORY

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, pills, or drugs? Yes No If Yes: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If Yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If Yes: _____

Are you on a special diet? Yes No If Yes: _____

Do you use tobacco? Yes No If Yes: _____

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 Anesthetics

Other? Yes No If Yes: _____

Do you use controlled substances? Yes No If Yes: _____

Do you have, or have you had, any of the following? Check any that apply

- 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 Problems 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 Tonsillitis
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

Other serious illness not listed above: _____

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 _____

Date _____