Medical History

Are you under a physician's care now? ◯ Yes ◯ No If yes, Why?_____

Have you ever had a major operation? ◯ Yes ◯ No If yes, What?_____

Have you ever had a serious head/neck injury? ◯ Yes ◯ No If yes,What?_____

Are you taking any medications? (Please list) ◯ Yes ◯ No If yes, List_____

Do you take, or have you taken Phen-Fen or Redux? ◯ Yes ◯ No

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates? ◯ Yes ◯ No If yes, What? _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No If yes, What?_____

Are you allergic to any of the following: Aspirin Penicillin Codeine Acrylic Metal Latex

Sulfa Drugs Local Anesthetics Other?_____

Women: Are you….. ◯ Pregnant/Trying to get pregnant? ◯ Nursing? ◯ Taking Oral Contraceptives?

Do you have, or have had, any of the following? CIRCLE ALL 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/Seizures	High Cholesterol	Scarlet Fever
Artifical Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artifical 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
Chemotheraphy	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

Any 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 of Patient, Parent or Guardian:

X_____ Date: _____