



MEDICAL HISTORY FORM

Patient Name:

Birth Date:

Today's date:

Although dental personnel primarily treats 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.

Please write the name and contact information of your primary care physician:

Your Height (in feet and inches):	
Your Weight (in pounds):	

Are you under a physician's care now? If yes, please indicate reason and physician contact information.	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Do you use tobacco? If yes, please indicate number of packs per day and for how long?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:

Are you taking any medications, pills or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list them:

Do you use controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Have you ever taken Fosamax, Boniva, Actonel or other medications containing bisphosphonates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Please list the emergency contact person(s): First and Last Name, phone number, and relationship:		

For women: Are you...		
<input type="checkbox"/> Pregnant / Trying to get pregnant	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Taking oral contraceptives?

Are you allergic to any of the following? Or cannot take any of the following?			
<input type="checkbox"/> Aspirin/Ibuprofen	<input type="checkbox"/> Penicillin/Amoxicillin/Augmentin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Iodine	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Tylenol			
Other allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:	



Do you have, or have you had any of the following?					
AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If diabetic, please indicate which type and most recent HbA1c	<input type="checkbox"/>		If yes:		
If high blood pressure, please comment on the level of control of your blood pressure	<input type="checkbox"/>		If yes:		
Have you ever had any serious illness not listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes:		
Do you need to take prophylactic antibiotic prior to dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

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:

Date: _____