Medical History

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with your dental health. Thank you for answering the following questions.

Please list all medications you are currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you allergic to any of the following? (circle all that apply)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Sulfa drugs

Please list allergies/reactions to medications, or other allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or someone that you have been in contact with tested positive for COVID-19? YES NO

Have you ever been hospitalized or had a operation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a physician’s care? Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? YES NO

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES NO

Are you pregnant? YES NO Nursing? YES NO

Do you use tobacco? YES NO Do you use controlled substances? YES NO Do you vape? YES NO

Do you have, or have you had, any of the following? (please check all that apply to you)

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

Have you ever had any serious illness not listed above? Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 child’s) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_