

MEDICAL HISTORY

Patient Name: _____

Date: _____

Are you currently under the care of a physician? Yes No N/A _____

Have you ever been hospitalized or had a major operation? Yes No N/A _____

Have you ever had a serious head and neck injury? Yes No N/A _____

Do you use controlled substances? Yes No N/A _____

Are you taking a bisphosphonate (e.g. Fosamax, Actonel)? Yes No N/A _____

Are you allergic to any of the following? Aspirin Sulfa Tetracycline Codeine Metal Latex Local Anesthetics
 Other: _____

Do you have any food or environmental allergies: Yes No Please List: _____

Do you have, or have you had, any of the following?

- | | | | | |
|--|--|---|---|---|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Chest palpitations | <input type="radio"/> Frequent Headaches | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Seizure Disorder |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Cold Sores | <input type="radio"/> Genital Herpes | <input type="radio"/> Kidney Disease | <input type="radio"/> Shaking/Tremors |
| <input type="radio"/> Anemia | <input type="radio"/> Congenital Heart Disease | <input type="radio"/> Glaucoma | <input type="radio"/> Leukemia/Lymphoma | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Angina Pectoris | <input type="radio"/> Cough (Chronic) | <input type="radio"/> Hay Fever | <input type="radio"/> Liver Disease | <input type="radio"/> Sinus Disease |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Lung Disease | <input type="radio"/> Stomach Disease |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Diarrhea (Chronic) | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke |
| <input type="radio"/> Asthma | <input type="radio"/> Drug Addiction | <input type="radio"/> Heart Valve Replacement | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Swelling of Extremities |
| <input type="radio"/> Blood Disease | <input type="radio"/> Easily Winded | <input type="radio"/> Hemophilia | <input type="radio"/> Psychiatric Disease | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Breathing Difficulty | <input type="radio"/> Emphysema | <input type="radio"/> Hepatitis (Any) | <input type="radio"/> Radiation Therapy | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Excessive Bleeding | <input type="radio"/> High Blood Pressure | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Tumors/Growths |
| <input type="radio"/> Cancer | <input type="radio"/> Excessive Thirst | <input type="radio"/> Hives/Rash | <input type="radio"/> Renal Dialysis | <input type="radio"/> Ulcers |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Fainting Spells | <input type="radio"/> Hypoglycemia | <input type="radio"/> Scarlet Fever | <input type="radio"/> Veneral Disease |
| <input type="radio"/> Chest Pains | <input type="radio"/> Fever (Chronic) | <input type="radio"/> Intestinal Disease | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Jaundice |

Have you had a serious disease or symptom not listed above? Yes No

Comments: _____

To the best of my knowledge, the information provided on this form is complete and accurate. I understand that providing incorrect information may be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

DATE