PATIENT MEDICAL HISTORY

Although dental personnel primarily treat 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.

1. Are you under physician's care now? If yes: 2. Have you been hospitalized or had a major operation? If yes: 3. Have you ever had a serious head or neck injury? If yes: 4. Are you taking any medications or drugs? If yes: 5. Do you take or have you taken Phen-Fen or Redux? 6. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? 7. Are you on a special diet? 8. Do you use tobacco? 9. Do you use controlled substances? If yes: WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO Are you allergic to any of the following? Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check all that apply) AIDS/HIV Positive Cortisone Medicine Hemophilia Radiation Treatments Alzheimer's Disease Diabetes Hepatitis A Recent Weight Loss Anaphylaxis Drug Addiction Herpes Rheumatic Fever Anemia Easily Winded Herpes Rheumatic Fever Anemia Emphysema High Blood Pressure Rheumatism Arthritis/Gout Epilepsy/Seizures High Cholesterol Scarlet Fever Artificial Joint Excessive Bleeding Hives or Rash Shingles Sickle Cell Disease Blood Disease Frequent Cough Kidney Problems Spina Bifida	Yes NO				
2. Have you been hospitalized or had a major operation? If yes: 3. Have you ever had a serious head or neck injury? If yes: 4. Are you taking any medications or drugs? If yes: 5. Do you take or have you taken Phen-Fen or Redux? 6. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? 7. Are you on a special diet? 8. Do you use tobacco? 9. Do you use ontrolled substances? If yes: WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO Are you allergic to any of the following? Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check 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 Rheumatic Fever Artificial Heart Valve Excessive Thirst Hypoglycemia Sickle Cell Disease Ashma Fainting / Dizziness Irregular Heartbeat Sinus Trouble Blood Transfusion Frequent Cough Kindey Problems Spina Bifda Bioad Transfusion Frequent Diarrhea Leukemia Sickle Cell Disease Trequent Headaches Liver Disease Trouble Storke Multina Sickle Cell Disease Trequent Headaches Leukemia Simus Trouble Storke Brusties Heart Murmur Pain in Jaw Joints Turboile Simus Brusting Problems Spina Bifda Storke/Feiburs Heart Murmur Pain in Jaw Joints Turboile Simus Trouble Storke Heart Murmur Pain in Jaw Joints Turboile Simus Trouble Storke Heart Hurmur Pain in Jaw Joints Turborion Simus Providing incorrect Compental Heart Disease Liver Disease Trequent Pain in Jaw Joints Turborio Growths Congental Heart Brooker Paerathyroid Disease Veneral Disease Psychiatric Care Veneral Dis	1. Are you under physician's care now? If yes:				
3. Have you ever had a serious head or neck injury? If yes: 4. Are you taking any medications or drugs? If yes: 5. Do you take or have you taken Phen-Fen or Redux? 6. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? 7. Are you on a special diet? 8. Do you use controlled substances? If yes: 9. Do you use controlled substances? If yes: WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO Are you allergic to any of the following? Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check all that apply) AIDS/HIV Positive Cortisone Medicine Hemophilia Radiation Treatments Atzheimer's Disease Diabetes Hepatitis A Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Anemia Easily Winded Herpes Rheumatic Fever Ardificial Heart Valve Encessive Bleeding Hives or Rash Shingles Artificial Heart Valve Excessive Thirst Excessive Thirst Excessive Thirst Propular Heartbeat Sinus Trouble Blood Disease Frequent Cough Kidney Problems Spria Biflida Leucemia Storach Heart Bearth Unimore Leucemia Sinach/Intestine Disease Prequent Diarrhea Leukemia Sinach/Intestine Disease Chemotherapy Hay Fever Genital Herpes Low Blood Pressure Swelling of Limbs Trouble Prequent Diarrhea Leukemia Sinach/Intestine Disease Chemotherapy Hay Fever Genital Herpes Low Blood Pressure Swelling of Limbs Trumors or Growths Uncers and Sulface Propulses Allera Preprints Thyroid Disease Thyroid Disease Thyroid Disease Series Preprint Diarrhea Leukemia Storach Trumors or Growths Uncers and Sulface Propulses Trumors or Growths Heart Rocemaker Parathyroid Disease Thyroid Disease Thyroi	2. Have you been hospitalized or had a major operation? If yes:				
4. Are you taking any medications or drugs? If yes: 5. Do you take or have you taken Phen-Fen or Redux? 6. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? 7. Are you on a special diet? 8. Do you use bloacco? 9. Do you use controlled substances? If yes: WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO Are you allergic to any of the following? Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check all that apply) AIDS/HIV Positive Cortisone Medicine Hemophilia Radiation Treatments Alzheimer's Disease Diabetes Hepatitis & Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis & C. Renal Dialysis Anaphylaxis Drug Addiction Hepatitis & C. Renal Dialysis Anglina Easily Winded Herpes Rheumatism Arthritis/Gout Epilepsy/Seizures High Cholesterol Scarlet Fever Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Blood Disease Frequent Cough Kidney Problems Sinkle Cell Disease Blood Transfusion Frequent Diarrhes Leukemia Sinkel Cell Disease Bruste Easily Genital Herpes Low Blood Pressure Swelling of Limbs Breathing Problems Frequent Diarrhes Leukemia Sinkoke Cell Disease Bruste Easily Genital Herpes Low Blood Pressure Swelling of Limbs Congenital Heart Border Heart Acceptable Oscarder Psychiatric Care Veneral Disease Chemotherapy Hay Fever Mittral Valve Prolepse Swelling of Limbs Congenital Heart Border Parathyroid Disease Veneral Disease Thyroid Disease Psychiatric Care Veneral Disease Comments: 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.					
6. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? 7. Are you on a special diet? 8. Do you use tobacco? 9. Do you use controlled substances? If yes: WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO Are you allergic to any of the following? Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check 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 Diabysis Anaphylaxis Anghina Easily Winded Herpes Rheumatics Angina Emphysema High Blood Pressure Rheumatism Arthritis/Gout Epilepsy/Seizures High Cholesterol Scarlet Fever Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Asthma Fainting / Dizziness Irregular Heartbeat Sinus Trouble Blood Transfusion Frequent Cough Kidney Problems Spina Bifida Blood Transfusion Frequent Headaches Liver Disease Stroke Brushe Easily Genital Herpes Low Blood Pressure Swelling of Limbs Breathing Problems Frequent Headaches Liver Disease Stroke Brushe Easily Genital Herpes Low Blood Pressure Swelling of Limbs Chemotherapy Hay Fever Mitterly Pain in Jaw Joints Turberculosis Chemotherapy Heart Attack/Failure Osteoporosis Turberculosis Chemotherapy Heart Pacemaker Parathyroid Disease Thyroid Disease Chemotherapy Heart Pacemaker Parathyroid Disease Ucloers Congenital Heart Disorder Heart Pacemaker Parathyroid Disease Ucloers Congenital Heart Disorder Heart Pacemaker Parathyroid Disease Turnors or Growths Have you ever had any serious lilness not listed above? YES / NO If yes: Comments: 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 ch					
7. Are you on a special diet? 8. Do you use tobacco? 9. Do you use controlled substances? If yes: WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO Are you allergic to any of the following? Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check 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 Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Angina Emphysema High Blood Pressure Rheumatic Fever Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Artificial Heart Valve Excessive Thirst Hypoglycemia Sickle Cell Disease Blood Disease Frequent Cough Kidney Problems Spina Bifida Blood Transfusion Frequent Headaches Leukemia Stomach/intestine Disease Breathing Problems Frequent Headaches Leukemia Stomach/intestine Disease Brashing Problems Heart Murmur Alay Fever Mitral Valve Prolapse Thyroid Disease Chemotherapy Hay Fever Mitral Valve Prolapse Thyroid Disease Chemotherapy Heart Pacemaker Parathyroid Disease Veneral Disease Convolusions Heart Trouble/Disease Psychiatric Care Veneral Disease Parathyroid Disease Veneral Disease Parathyroid Disease Veneral Disease Frequents: 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.					
			or any cancer medications conta	aining bisphosphonates?	
WOMEN ONLY: Are you: Pregnant, trying to get pregnant or nursing? YES / NO Taking oral contraceptives? YES / NO Are you allergic to any of the following? AspirinPenicillinSulfa DrugsCodeineAcrylic/MetalLatexAnestheticsOther					
Are you allergic to any of the following? _Aspirin _ Penicillin _ Sulfa Drugs _ Codeine _ Acrylic/Metal _ Latex _ Anesthetics _ Other	9. Do you use con	trolled substances? If yes:			
Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check all that apply) AIDS/HIV Positive Cortisone Medicine Hemophilia Recent Weight Loss Recent Weight Loss Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Renal Dialysis Recent Weight Loss Recent Weight Loss Renal Dialysis Recent Weight Loss Recent Heard Very Recent Heart Science Recent Heard Science Recent Heart Science Recent Heart Science Recent	WOMEN ONLY: Are you: Pr	regnant, trying to get pregnant or	nursing? YES / NO Taking ora	contraceptives? YES / NO	
Aspirin Penicillin Sulfa Drugs Codeine Acrylic/Metal Latex Anesthetics Other Do you have or have you ever been told you have any of the following? (check all that apply) AIDS/HIV Positive Cortisone Medicine Hemophilia Recent Weight Loss Recent Weight Loss Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Renal Dialysis Recent Weight Loss Recent Weight Loss Renal Dialysis Recent Weight Loss Recent Heard Very Recent Heart Science Recent Heard Science Recent Heart Science Recent Heart Science Recent	Are you allergic to any	of the following?			
Do you have or have you ever been told you have any of the following? (check all that apply) AIDS/HIV Positive			Metal Latex Anesthetics	Other	
AlDS/HIV Positive Cortisone Medicine Diabetes Hepatitis A Recent Weight Loss Ranaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Renal Dialysis Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Recent Weight Loss Recent Height Blood Pressure Recent Height Blood Pressure Rheumatism Pressure					
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 Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Artificial Joint Excessive Thirst Hypoglycemia Sickle Cell Disease Artificial Joint Excessive Thirst Hypoglycemia Sickle Cell Disease Irregular Heartbeat Sinus Trouble Blood Disease Frequent Cough Kidney Problems Spina Bifida Blood Transfusion Frequent Diarrhea Leukemia Stomachintestine 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 Tonsilitis Code Sores/Fever Blisters Heart Murmur Pain in Jaw Joints Tumors or Growths Congenital Heart Disorder Heart Trouble/Disease Psychiatric Care Veneral Disease Yellow Jaundice 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.	Do you have or have yo	ou ever been told you have	any of the following? (chec	k all that apply)	
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 Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Artificial Joint Excessive Thirst Hypoglycemia Sickle Cell Disease Artificial Joint Excessive Thirst Hypoglycemia Sickle Cell Disease Irregular Heartbeat Sinus Trouble Blood Disease Frequent Cough Kidney Problems Spina Bifida Blood Transfusion Frequent Diarrhea Leukemia Stomachintestine 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 Tonsilitis Code Sores/Fever Blisters Heart Murmur Pain in Jaw Joints Tumors or Growths Congenital Heart Disorder Heart Trouble/Disease Psychiatric Care Veneral Disease Yellow Jaundice 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.	AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments	
Anaphylaxis					
AnemiaEasily WindedHerpesRheumatic FeverAnginaEmphysemaHigh Blood PressureRheumatismRheumatismArthritis/GoutEpilepsy/SeizuresHigh CholesterolScarlet FeverArtificial Heart ValveExcessive BleedingHives or RashShinglesArtificial JointExcessive ThirstHypoglycemiaSickle Cell DiseaseAsthmaFainting / DizzinessIrregular HeartbeatSinus TroubleSlood DiseaseFrequent CoughKidney ProblemsSpina BifidaStomach/Intestine DiseaseStrokeSt	The state of the s				
Angina				The state of the s	
Artificial Heart Valve	Angina	the state of the s	High Blood Pressure		
Artificial Joint	Arthritis/Gout	Epilepsy/Seizures	High Cholesterol	Scarlet Fever	
Artificial Joint	Artificial Heart Valve	Excessive Bleeding		Shingles	
Blood Disease	Artificial Joint	Excessive Thirst	Hypoglycemia		
Blood Transfusion	Asthma	Fainting / Dizziness	Irregular Heartbeat	Sinus Trouble	
Breathing Problems	Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida	
Bruise Easily Genital Herpes Low Blood Pressure Swelling of Limbs Cancer Glaucoma Lung Disease Thyroid Disease Chemotherapy Hay Fever Mitral Valve Prolapse Tonsilitis 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 Veneral Disease Yellow Jaundice 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.	Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestine Disease	
Cancer Glaucoma Lung Disease Thyroid Disease Chemotherapy Hay Fever Mitral Valve Prolapse Tonsilitis 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 Veneral Disease Yellow Jaundice Have you ever had any serious illness not listed above? YES / NO If yes: Comments: 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.		Frequent Headaches	Liver Disease	Stroke	
ChemotherapyHay FeverMitral Valve ProlapseTonsilitisChest painsHeart Attack/FailureOsteoporosisTuberculosisTuberculosisCold Sores/Fever BlistersHeart MurmurPain in Jaw JointsTumors or GrowthsCongenital Heart DisorderHeart PacemakerParathyroid DiseaseUlcersConvulsionsHeart Trouble/DiseasePsychiatric CareVeneral DiseaseYellow Jaundice		Genital Herpes	Low Blood Pressure	Swelling of Limbs	
Chest pains	Cancer	Glaucoma	Lung Disease	Thyroid Disease	
		Hay Fever	Mitral Valve Prolapse		
Congenital Heart DisorderHeart PacemakerParathyroid DiseaseUlcersVeneral DiseaseYellow JaundiceYellow JaundiceYello	Chest pains	Heart Attack/Failure		Tuberculosis	
ConvulsionsHeart Trouble/DiseasePsychiatric CareVeneral DiseaseYellow Jaundice Have you ever had any serious illness not listed above? YES / NO If yes: Comments: 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.		Heart Murmur	Pain in Jaw Joints	Tumors or Growths	
Yellow Jaundice Have you ever had any serious illness not listed above? YES / NO If yes: Comments: 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.					
Have you ever had any serious illness not listed above? YES / NO If yes: Comments: 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.		Heart Trouble/Disease	Psychiatric Care	Veneral Disease	
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.	Yellow Jaundice				
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.	Have you ever had any serious	s illness not listed above? YES / NO	If yes:		
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.	Comments:				
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.	Comments.				
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.					
Patient's Signature (Parent or Guardian) Date	information can be dangerous				
Patient's Signature (Parent or Guardian) Date					
	Patient's Signature (Parent	or Guardian)		te	