Patient Medical History

Name:_______________________________________ **Date Of Birth**:______________

Although dental personnel primarily treat the area around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could effect your dental treatment you will receive. Thank you for answering the following questions.

Are you under the care of a physician currently? □Yes □No
If yes, please explain: ____

Have you ever been hospitalized or had a major operation? □Yes □No
If yes, please explain: ____

Are you taking any medications, pills, or drugs? □Yes □No
If yes, please list:
____
____
____

Do you currently or have you ever taken a medication for your bones? (ie: Fosamax, Boniva, Prolia)
□ Yes □ No

Do you use tobacco? □Yes □No
If yes, how long? ____

Women Only: Are you….
□Pregnant
□Nursing?
□Taking Oral Contraceptives?

Are you allergic to the following?
□Aspirin □Penicillin □Codeine
□Acrylic □Metal □Latex
□Other____________________________

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

□ AIDS/HIV+	□ Blood Thinners	□ Excessive Bleeding	□ Hepatitis B or C	□ Rheumatism
□ Alzheimer’s disease	□ Cancer	□ Fainting/Dizziness	□ High Blood Pressure	□ Sickle Cell
□ Anaphylaxis	□ Chemotherapy	□ Frequent Cough	□ Hypoglycemia	□ Sinus Trouble
□ Anemia	□ Chest Pain	□ Frequent Headaches	□ Irregular Heartbeat	□ Stomach Dis.
□ Angina	□ Cold sores/Fever Blisters	□ Glaucoma	□ Kidney Problems	□ Stroke
□ Arthritis/Gout	□ Congenital Heart Dis.	□ Heart Attack/Failure	□ Leukemia	□ Thyroid Dis
□ Artificial Heart Valve	□ Diabetes	□ Heart Murmur	□ Liver Disease	□ Tuberculosis
□ Artificial Joint	□ Drug Addiction	□ Heart Pace Maker	□ Low Blood Pressure	□ Tumors
□ Asthma	□ Dry Mouth	□ Heart Trouble/Disease	□ Lung Disease	
□ Blood Disease	□ Emphysema	□ Hemophilia	□ Jaw Pain	
□ Breathing Problems	□ Epilepsy/Seizures	□ Hepatitis A	□ Radiation	

Have you ever had any serious illness not listed above? □Yes □No
If Yes, please explain: ____
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To the best of my knowledge, the questions on this form have been answered accurately. 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 charges in medical status.
Signature:____ Date:________________________