MEDICAL HISTORY

PATIENT NAME ______________________ BIRTH DATE ______________________

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No
Are you taking any medication, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
◯ Asprin ◯ Penicilin ◯ Codine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa drugs
◯ Other If yes, please explain: ______________________

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

Condition		Condition		Condition		Condition	
Cardiovascular disease	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Bronchitis	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Rheumatic fever	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Thyroid problems	◯ Yes ◯ No
Congestive heart failure	◯ Yes ◯ No	Abnormal bleeding	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Damaged heart valves	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Liver disease	◯ Yes ◯ No
Heart attack	◯ Yes ◯ No	AIDS or HIV infection	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No
Heart murmur	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Chemotherapy/ Radiation	◯ Yes ◯ No	Fainting spells	◯ Yes ◯ No
Low blood pressure	◯ Yes ◯ No	Autoimmune disease	◯ Yes ◯ No	Diabetes Type I or II	◯ Yes ◯ No	Kidney problems	◯ Yes ◯ No
High blood pressure	◯ Yes ◯ No	Rheumatoid arthritis	◯ Yes ◯ No	Eating disorder	◯ Yes ◯ No	Psychiatric care	◯ Yes ◯ No
Congenital heart defects	◯ Yes ◯ No	Systemic lupus	◯ Yes ◯ No	Gastrointestinal disease	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Mitral valve prolapse	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Reflux / heartburn	◯ Yes ◯ No	Any implantable device	◯ Yes ◯ No

Have you had an orthopedic total joint replacement? ◯ Yes ◯ No If Yes, Date:________ Have you had any complications? ____________
Artificial (prosthetic) heart valve ◯ Yes ◯ No
Previous infective endocarditis ◯ Yes ◯ No
Damaged valves in transplanted heart ◯ Yes ◯ No
Congential heart disease (CHD) ◯ Yes ◯ No
- Unrepaired, cyanotic CHD ◯ Yes ◯ No
- Repaired (completely) in the last 6 months ◯ Yes ◯ No
- Repaired CHD with residual defects ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ______________________

Comments: ______________________
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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____________