JONES
FAMILY DENTISTRY

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: _____

Are you allergic to any of the following:
○ Asprin ○ Penicilin ○ Codeine ○ Local Anesthetics
○ Acrylic ○ Metal ○ Latex ○ Sulfa Drugs ○ Other
If yes please explain:_____

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

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

Cardiovascular disease..... ○ Yes ○ No	Rheumatic fever..... ○ Yes ○ No	Eating disorder..... ○ Yes ○ No
Angina..... ○ Yes ○ No	Abnormal bleeding..... ○ Yes ○ No	Gastrointestinal disease ○ Yes ○ No
Congestive heart failure.... ○ Yes ○ No	Anemia..... ○ Yes ○ No	Reflux / heartburn..... ○ Yes ○ No
Heart attack..... ○ Yes ○ No	AIDS or HIV infection..... ○ Yes ○ No	Thyroid problems..... ○ Yes ○ No
Heart murmur..... ○ Yes ○ No	Arthritis..... ○ Yes ○ No	Stroke..... ○ Yes ○ No
Low blood pressure..... ○ Yes ○ No	Autoimmune disease..... ○ Yes ○ No	Liver disease..... ○ Yes ○ No
High blood pressure..... ○ Yes ○ No	Rheumatoid arthritis..... ○ Yes ○ No	Epilepsy..... ○ Yes ○ No
Congenital heart disease.. ○ Yes ○ No	Systemic lupus ..... ○ Yes ○ No	Fainting spells..... ○ Yes ○ No
Artificial (prosthetic)	Asthma..... ○ Yes ○ No	Kidney problems..... ○ Yes ○ No
heart valve..... ○ Yes ○ No	Bronchitis..... ○ Yes ○ No	Psychiatric care..... ○ Yes ○ No
Previous infective	Emphysema..... ○ Yes ○ No	Osteoporosis..... ○ Yes ○ No
endocarditis..... ○ Yes ○ No	Sinus trouble..... ○ Yes ○ No	Obstructive sleep apnea ○ Yes ○ No
Damaged valves in	Tuberculosis..... ○ Yes ○ No	Any implantable device ○ Yes ○ No
transplanted heart.... ○ Yes ○ No	Cancer..... ○ Yes ○ No	Orthopedic total joint
Mitral valve prolapse..... ○ Yes ○ No	Chemotherapy/ Radiation ○ Yes ○ No	replacement..... ○ Yes ○ No
Pacemaker..... ○ Yes ○ No	Diabetes Type I or II..... ○ Yes ○ No	If Yes, Date _____
		Any complications? _____
		_____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____