Medical Information

PATIENT NAME :_______________________________________ Birthdate: __________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have or medications you may be taking, could have an important interrelationship with the treatment received.

Medical Doctor's Name(s) _______________________________________**Phone:** ____________________

Have you ever been hospitalized or had a major operation? ○**Yes** **No** Explain: ________________________________

Have you ever had a serious head or neck injury? ○**Yes** **No** Explain: ________________________________

Are you taking any medications, pills, or drugs? ○**Yes** **No** Explain: ________________________________

Do you or have you taken: Phen-Fen or Redux ? ○**Yes** **No** Explain: ________________________________

Have you ever taken Fosamax, Boniva, Actonel, or any other meds containing bisphosphonates? ○**Yes** **No** Explain: ________________________________

Have you had a knee, hip, or joint replaced? ○**Yes** **No** Explain: ________________________________

Do you take a blood thinner? (Coumadin/ Warfarin/Other) ○**Yes** **No** Explain: ________________________________

Autistic and/or Sensory Issues? ○**Yes** **NO** Explain: ________________________________

Do you use tobacco products ? **Yes** **NO** Explain ________________________________

FOR WOMEN : **Are you:** ○ **Pregnant/ Trying to get pregnant** ○ **Nursing** ○ **Taking Oral Contraceptives?**

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic
○ Metal ○ Latex ○ Sulfa Drugs ○ Local Anesthetics

Other, or explain: ____

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

○ AIDS/ HIV Positive
○ Alzheimer's Disease
○ Anaphylaxis
○ Anemia
○ Angina
○ Arthritis/ Gout
○ Artificial Heart Valve
○ Artificial Joint
○ Asthma
○ Blood Disease
○ Blood Transfusion
○ Breathing Problem
○ Bruise Easily
○ Cancer
○ Chemotherapy
○ Chest Pains
○ Cold Sores/Fever Blister
○ Congen. Heart Disorder
○ Convulsions
○ Cortisone Medicine
○ Diabetes
○ Drug Addiction
○ Easily Winded
○ Emphysema
○ Epilepsy or Seizures
○ Excessive Bleeding
○ Excessive Thirst
○ Fainting Spells/ Dizziness
○ Frequent Cough
○ Frequent Diarrhea
○ Frequent Headaches
○ Genital Herpes
○ Glaucoma
○ Hay Fever
○ Heart Attack
○ Heart Murmur
○ Heart Pacemaker
○ Heart Trouble/ Disease
○ Hemophilia
○ Hepatitis A
○ Hepatitis B or C
○ Herpes
○ High Blood Pressure
○ High Cholesterol
○ Hives or Rash
○ Hypoglycemia
○ Irregular Heartbeat
○ Kidney Problems
○ Leukemia
○ Liver Disease
○ Low Blood Pressure
○ Lung Disease
○ Mitral Valve Prolapse
○ Osteoporosis
○ Pain in Jaw Joints
○ Parathyroid Disease
○ Psychiatric Care
○ Radiation Treatment
○ Recent Weight Loss
○ Renal Dialysis
○ Rheumatic Fever
○ Rheumatism
○ Scarlet Fever
○ Shingles
○ Sickle Cell Disease
○ Sinus Trouble
○ Spina Bifida
○ Stomach/ Intestinal Disease
○ Stroke
○ Swelling of Limbs
○ Thyroid Disease
○ Tonsillitis
○ Tuberculosis
○ Tumors or Growths
○ Ulcers
○ Venereal Disease
○ Yellow Jaundice

Other/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: ______________________________________ Date: ______________