

Medical History Form

Patient Name:

Birth Date:

Date Created:

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
Have you ever been hospitalized or had a major operation? Yes No If yes
Have you ever had a serious head or neck injury? Yes No If yes
Are you taking any medications, pills, or drugs? Yes No If yes
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes
Are you on a special diet? Yes No
Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin
Nickel

Penicillin
Latex

Codeine
Sulfa Drugs

Acrylic

- Do you use controlled substances? Yes No If yes
Other? If yes

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

Table with 3 columns of medical conditions and Yes/No/If yes options. Conditions include AIDS/HIV, Diabetes, Hemophilia, Radiation Treatments, Alzheimer's Disease, etc.

Have you ever had any serious illness not listed 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.

Signature of Patient, Parent or Guardian:

X _____

Date: _____