

PATIENT NAME: _____ **BIRTHDATE** _____

Medical History Form

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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: _____

Do you take any supplements?..... **YES** __ **NO** __

If **YES** please list: _____

Are you taking and/or using any medication, pills, or drugs?..... **YES** __ **NO** __

If **YES** please list: _____

Do you require pre-medication (antibiotics) prior to your dental appointment?..... **YES** __ **NO** __

If **YES** please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications for Osteoporosis?..... **YES** __ **NO** __

If **YES** please list: _____

Are you taking any blood thinners? If yes, which one?..... **YES** __ **NO** __

If **YES** please list: _____

Do you take Rx Fluoride?..... **YES** __ **NO** __

Do you use tobacco?..... **YES** __ **NO** __

Who is your Medical Doctor/Clinic _____

WOMEN: Please select any of the following that apply.

Pregnant/Trying to get pregnant?..... Nursing?..... Taking Oral Contraceptives?

EVERYONE: Are you allergic to any of the following?

Aspirin..... Penicillin..... Codeine..... Acrylic

Metals..... Latex..... Sulfa Drugs..... Local Anesthetics

OTHER.....If **OTHER** please list:_____

Please **CIRCLE** if you have, or you had, any of the following?

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Renal Dialysis	Anemia
Herpes	Angina	High Blood Pressure	Arthritis/Gout
Epilepsy or Seizures	High Cholesterol	Artificial Heart Valve	Excessive Bleeding
Hives or Rash	Shingles	Artificial Joint	Excessive Thirst
Hypoglycemia	Sickle Cell Disease	Asthma	Fainting Spells/Dizziness
Irregular Heartbeat	Blood Disease	Frequent Cough	Kidney Problems
Blood Transfusions	Leukemia	Stomach/Intestinal Disease	Breathing Problems
Frequent Headaches	Liver Disease	Stroke	Bruise Easily
Low Blood Pressure	Swelling of Limbs	Cancer	Lung Disease
Thyroid Disease	Chemotherapy	Mitral Valve Prolapse	Chest Pains
Heart Attack/Failure	Tuberculosis	Cold Sores/Fever Blisters	Heart Murmur
Pain in Jaw Joints	Tumors or Growths	Congenital Heart Disease	Heart Pacemaker
Convulsions	Heart Trouble/Disease	Psychiatric Care	

Have you had any other serious illness not listed above?.....**YES** **NO**

If **YES** please explain:_____

Do you have **Sleep Apnea**?.....**YES** **NO**

If **YES** do you use a **CPAP machine**?.....**YES** **NO**