

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Address \_\_\_\_\_ Weight \_\_\_\_\_ Home Phone No. \_\_\_\_\_  
 \_\_\_\_\_ Height \_\_\_\_\_ Work Phone No. \_\_\_\_\_  
 \_\_\_\_\_ SSN # \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person? Your Name \_\_\_\_\_ Relationship \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Are you now under the care of a physician? YES  NO

If yes, for what reason? \_\_\_\_\_

Are you presently taking any medications / drugs / pills? YES  NO

**ALLERGIES / SENSITIVITIES:**

Are you allergic / sensitive (or ever had an adverse reaction) to: *Check all that apply or check none*

- Penicillin  Codeine  Local Anesthetic  Metals  LATEX  
 Aspirin  Other Antibiotics  Other Medications or Substances  NONE

List all medications prescribed by your physician (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances.

**Do you have, or have you ever had any of the following: (YES or NO)**

	YES	NO		YES	NO		YES	NO		YES	NO
1 Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	13 Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	29 Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>	45 Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>
2 Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	14 Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	30 Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	46 Artificial Joint / Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
3 Damaged valves in transplanted heart	<input type="checkbox"/>	<input type="checkbox"/>	15 Lung disease / COPD	<input type="checkbox"/>	<input type="checkbox"/>	31 Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	47 Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
4 Congenital heart disease (CHD)			16 Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	32 Anemia	<input type="checkbox"/>	<input type="checkbox"/>	48 Hepatitis (circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	17 Asthma	<input type="checkbox"/>	<input type="checkbox"/>	33 Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Type A B C Other		
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	18 Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	34 Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	49 Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	19 Respiratory Ailments	<input type="checkbox"/>	<input type="checkbox"/>	35 Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	50 Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
5 Heart Disease/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	20 Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	36 Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	51 GERD (gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>
6 Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	21 Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	37 Cancer	<input type="checkbox"/>	<input type="checkbox"/>	52 Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>
7 Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	22 Diabetes Type I or Type II	<input type="checkbox"/>	<input type="checkbox"/>	38 Tumors	<input type="checkbox"/>	<input type="checkbox"/>	53 Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
8 Rheumatic fever/heart disease	<input type="checkbox"/>	<input type="checkbox"/>	23 Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	39 Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	54 Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>
9 Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	24 Persistent swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	40 Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	55 Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
10 High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	25 Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	41 Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	56 Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
11 Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	26 Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	42 Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	57 Removal of Spleen	<input type="checkbox"/>	<input type="checkbox"/>
12 Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	27 HIV Positive / AIDS / ARC	<input type="checkbox"/>	<input type="checkbox"/>	43 Stroke	<input type="checkbox"/>	<input type="checkbox"/>	58 Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
			28 Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>	44 Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	59 Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>

**BISPHOSPHONATES**

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for osteoporosis or Paget's disease?  YES  NO

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?  YES  NO Date Treatment Began \_\_\_\_/\_\_\_\_/\_\_\_\_

**DR COMMENTS**

BLOOD PRESSURE

/

Have you ever used or currently use tobacco products?  YES  NO How much? \_\_\_\_\_ How Often? \_\_\_\_\_  
 cigarettes  cigars  pipe  chew How long ago did you quit? \_\_\_\_\_

Do you drink alcoholic beverages?  YES  NO How much? \_\_\_\_\_ How often? \_\_\_\_\_

Have you had any other serious illness, hospitalization or accident?  YES  NO

If yes, please explain \_\_\_\_\_

**WOMEN:** Are you pregnant or suspect that you may be?  YES  NO  
 Are you nursing?  YES  NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (PARENT/GUARDIAN)

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_