Care Dental Medical History

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, c

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
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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? ☐ If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No				

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Dental History

Are your teeth sensitive to hot and cold?	◯ Yes ◯ No	If yes
Does your gum bleed easily?	◯ Yes ◯ No	
Do you gag easily?	◯ Yes ◯ No	
Abcess in mouth?	◯ Yes ◯ No	

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:_____