MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

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 _____
Have you ever been hospitalized/or major surgery? ☐ Yes ☐ No _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No_____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No **** SEE BACK OF SHEET TO LIST ****
Do you take or have you taken Phen-Fen or Redux? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you: ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Amoxicillin ☐ Erythromycin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Sulfa Drugs ☐ Food Allergies ☐ Barbiturates, Sedatives, etc. ☐ Other _____

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

☐ Yes ☐ No I AM INTERESTED IN ORTHODONTICS (BRACES) TO STRAIGHTEN MY TEETH.

☐ Yes ☐ No I AM INTERESTED IN COSMETIC DENTISTRY.

☐ Yes ☐ No I AM CONCERNED ABOUT MY BREATH.

☐ Yes ☐ No I AM INTERESTED IN BLEACHING (WHITENING) MY TEATH.

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status in the future prior to treatment. I understand that I will be asked to update this page on a regular basis.

_____ _____
Signature of Patient, Parent, or Guardian Date

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU ARE TAKING:

CARDIOVASCULAR MEDICATION

ASPIRIN
CALAN (VERAPAMIL)
DIGOXIN
INDERAL (PROPANOLOL)
LASIX (FUROSEMIDE)
MIDAMOR (CHLOROTHIAZINE)
NITROGLYCERIN (NITROSTAT)
PROCARDIA XL (NIFEDIPINE)
TRICOR
ZESTRIL (LISINOPRIL)
ACCUPRIL (QUINAPRIL)
CORGARD (NADOLOL)
COUMADIN (WARFARIN)
LABETALOL
LOPRESSOR (METAPROLOL)
MONOPRIL (FOSINOPRIL)
PLAVIX
TENORMIN (ATENOLOL)
ZOCOR

RESPIRATORY MEDICATION

AEROBID
ATROVENT
COMBIVENT
PROVENTIL
SEREVENT
VANCER
ADVARE
AZMACORT
FLOVENT
PULMICORT
THEODUR (THEOPHYLLINE)
VENTOLIN (ALBUTEROL)

OSTEOPOROSIS MEDICATION

ACTONEL
FOSAMAX
RECLAST
BONIVA
MIRAPEX
REQUIP

ANXIETY / DEPRESSION MEDICATION

ATIVAN (LORAZEPAM)
CYMBALTA
EFFEXOR
LEXAPRO
XANAX
VALIUM
BUSPAR (BUSPIRONE)
PAXIL (PAROXETINE)
PROZAC (FLUOXETINE)
WELLBUTRIN (BUPROPION)
ZOLOFT

THYROID MEDICATION

LEVOTHYROXINE
LEVOXYL
SYNTHROID

CHOLESTEROL MEDICATION

CRESTOR
LIPITOR
MEVACOR
PRAVACHOL

DIABETES MEDICATION

DIABETA
INSULIN
HUMULIN
WELCHOL
GLUCOPHAGE (METFORMIN)
GLUCOTROL

PAIN MEDICATION

HYDROCODONE
LYRICA (PREGABALIN)
MOBIC (MELOXICAM)
MORPHINE
OXYCODONE
TOPAMAX (TOPIRAMATE)
ULTRAM (TRAMADOL)

ARTHRITIS MEDICATION

DOLOBID (DIFLUNISAL)
NALFON (FENOPROFEN)
VOLTAREN (DICLOFENAC)

STERIOD MEDICATION

PREDINSONE
MEDROL DOSEPAC

PLEASE LIST **ANY** *MEDICATIONS* OR *SUPPLEMENTS* YOU ARE TAKING AND NOT LISTED ABOVE.

NAME OF MEDICATION	WHY NEEDED	DOSAGE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____