Name_____

Medical History Form

Your mouth plays a vital role in the health and well-being 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.

Question	YES	NO	If yes, please include details here:
Are you under a physician's Care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills or drugs?			
Do you use any controlled substances?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Are you on a special diet?			
Do you use tobacco?			

Women, Are you…		
Pregnant ☐	Nursing ☐	Taking Oral Contraceptives ☐

Are you allergic to any of the following?			
Aspirin ☐	Penicillin ☐	Codeine ☐	Acrylic ☐
Metal ☐	Latex ☐	Sulfa Drugs ☐	Local Anesthetics ☐
Any other Known Allergies?			

Do you experience any of the following during your dental visits?		
Anxiety ☐	Dental Phobia ☐	Trouble with Dental Chair ☐

Name_____

Medical History Form

Your mouth plays a vital role in the health and well-being 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.

Do you have or have you had any of the following?			
AIDS/ HIV Positive ☐	Angina/ Chest Pain ☐	Autism ☐	Artificial Heart Valve ☐
Diabetes ☐	Asthma ☐	Psychiatric Care ☐	Congenital Heart Disease ☐
Blood Disease ☐	Breathing Problems ☐	Drug Addiction ☐	Heart Attack/Failure ☐
Bruise Easily ☐	Easily Winded ☐	Rheumatic Fever ☐	Heart Murmur ☐
Cold Sore/ Fever Blister ☐	Tuberculosis ☐	Scarlet Fever ☐	Pacemaker ☐
Jaundice ☐	Emphysema ☐	Frequent Headaches ☐	Heart Trouble/Disease ☐
Excessive Bleeding ☐	Frequent Cough ☐	Stroke ☐	Mitral Valve Prolapse ☐
Hemophilia ☐	Lung Disease ☐	Alzheimer's/Dementia ☐	Chemotherapy ☐
Blood Transfusion ☐	Sinus Trouble ☐	Kidney Problems ☐	Cancer ☐
Hepatitis A ☐	Thyroid Disease ☐	Renal Disease ☐	Tumors ☐
Hepatitis B ☐	Tonsillitis ☐	Liver Disease ☐	Growths ☐
Hepatitis C ☐	Glaucoma ☐	Stomach/Intestinal Disease ☐	Radiation Treatments ☐
Anemia ☐	Hay Fever ☐	Ulcers ☐	Epilepsy/Seizures ☐
Blood Disease ☐	Shingles ☐	Arthritis/Gout ☐	High/Low Blood Pressure ☐
Hypoglycemia ☐	Cortisone Medicine ☐	Rheumatism ☐	Artificial Joint ☐
Sickle Cell Disease ☐	Excessive Thirst ☐	Pain in Jaw Joints ☐	

If you have selected Yes to any of the above, please provide us with important details here:

Have you ever had any serious illnesses that have not been listed?

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_____Date_____