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Patient Name: ______________________________
Date: _____________

Medical History

Although dental professionals primarily treat the mouth and areas surrounding it, your mouth is an important part of your overall health. Health problems that you may have currently or in the past and medications that you may take or have taken play an important role in the dental care you will receive. Please let us know if you feel uncomfortable answering any questions. As always, your privacy is of the utmost importance.

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?_______________
____
____
____

Have you ever taken Fosamax, Boniva, Actonel, Prolia or any other bisphosphonate medication?
☐ Yes ☐ No
If yes, how long ago and for what length of time:
____

Do you use tobacco? ☐ Yes ☐ No
If yes, which kind: ☐ Smoke ☐ Smokeless

Do you use controlled substances? ☐ Yes ☐ No
If yes, what? _____________________

Are you allergic to any of the following?
Aspirin ☐ Penicillin/Amoxicillin ☐
Codeine ☐ Acrylic ☐
Latex ☐ Sulfa Drugs ☐
Local Anesthetics ☐ Other ☐ : _____________

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

AIDS/HIV Positive ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No
If so, approximate year of placement: _______
Artificial Heart Valve ☐ Yes ☐ No
If so, approximate year of placement: _______
Asthma ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No
Cold Sores ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
If so, has it been repaired? _______
COPD ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Drug Addiction ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Epilepsy or Seizures ☐ Yes ☐ No
Excessive Bleeding ☐ Yes ☐ No
Fainting Spells/Dizziness ☐ Yes ☐ No
Frequent Cough ☐ Yes ☐ No
Frequent Diarrhea ☐ Yes ☐ No
Frequent Headaches ☐ Yes ☐ No
Heart Attack/Failure ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Heart Pacemaker ☐ Yes ☐ No
Heart Trouble/Disease ☐ Yes ☐ No
Hemophilia ☐ Yea ☐ No
Hepatitis A ☐ Yes ☐ No
Hepatitis B or C ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Hypoglycemia ☐ Yes ☐ No
Infective Endocarditis ☐ Yes ☐ No
Irregular Heartbeat ☐ Yes ☐ No
Kidney Problems ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Lung Disease ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pain in jaw joint/TMJ ☐ Yes ☐ No
Parathyroid Disease ☐ Yes ☐ No
Prosthetic Joint Infection ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No
Radiation Treatment ☐ Yes ☐ No
Renal Dialysis ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Rheumatoid Arthritis ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Sensory Disorders ☐ Yes ☐ No
Stomach/Intestinal Disease ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tumors ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No

Women (Check all that apply): ☐ Pregnant ☐ Nursing
Signature:________________________. Date: ________