Medical History

Patient Full Name:_____ Birth Date: _____

Although dental personnel treat the area in and around your mouth, your mouth is 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 treatment you will receive at The Tooth Doctors. Thank you for answering the following questions

Are you under a physcian's care now? ◯ yes ◉ no If yes, please explain:_____
Have you ever been hospitalized or had a major operation? ◯ yes ◉ no If yes, please explain:_____
have you ever had a serious head or neck injury? ◯ yes ◉ no If yes, please explain:_____
Are you taking any medication, pills, or drugs? ◯ yes ◉ no If yes, please explain:_____
Do you take, or have you taken Phen-Fen or Redux? ◯ yes ◉ no If yes, please explain:_____
Have you ever taken Boniva, Actonel, or any other medication containing bisphosphonates? ◯ yes ◉ no If yes, please explain:_____
Are you on a special diet? ◯ yes ◉ no If yes, please explain:_____
Do you use tobacco? ◯ yes ◉ no If yes, please explain:_____
Do you use controlled substances? ◯ yes ◉ no If yes, please explain:_____

Women: Are You?

☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Asprin ☐ Metal ☐ Penicillin ☐ Latex ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic
☐ Local Anesthetics ☐ Other_____

Do you have, or have you had, any of the following? Check all that apply

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

Have you ever had any serious illness not listed above? ◯ yes ◯ no _____

Comments

Signature:_____ Date: _____ SUBMIT