New Medical History October 2017(Copy)

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Physician		Comment	
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	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, include over the counter medications, aspirin, blood thinners etc?	○ Yes ○ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No	If yes	
Do you use tobacco or e-cigarettes?	○ 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?

A-Fibrillation ○ Yes ○ No	Acid Reflux ○ Yes ○ No	AIDS/HIV Positive ○ Yes ○ No	Alzheimers' Disease ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Anemia ○ Yes ○ No	Angina ○ Yes ○ No	Arthritis/Gout/Rheumatism ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Artificial Joint ○ Yes ○ No	Asthma ○ Yes ○ No	Blood Disease/Hemophelia ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Cancer/Leukemia ○ Yes ○ No	Chemotherapy/Radiation ○ Yes ○ No	Chest Pain ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Congenital Heart Disorder ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Diabetes ○ Yes ○ No
Drug Addiction ○ Yes ○ No	Epilepsy/Seizure/Convulsion ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No
Frequent Cough ○ Yes ○ No	Frequent Headache ○ Yes ○ No	Glaucoma ○ Yes ○ No	Hay Fever/Sinus ○ Yes ○ No
Heart Attack/Failure ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No
Hepatitis A,B or C ○ Yes ○ No	Herpes ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	High Cholesterol ○ Yes ○ No
Hypoglycemia ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Liver Disease/Jaundice ○ Yes ○ No
Low Blood Pressure ○ Yes ○ No	Lung Disease/Emphyzema ○ Yes ○ No	Lymes Disease ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No
Osteoporosis ○ Yes ○ No	Pain in Jaw Joint ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Renal Dialyisis ○ Yes ○ No
Rheumatic/Scarlet Fever ○ Yes ○ No	Shingles ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No	Sleep Apnea ○ Yes ○ No
Spina Bifida ○ Yes ○ No	Stomach/intestinal Disease ○ Yes ○ No	Stroke ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Thyroid/Parathyroid Disease ○ Yes ○ No	Tuberculosis ○ Yes ○ No	Tumors or Growths ○ Yes ○ No	Ulcers ○ Yes ○ No

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

Comments

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:_____