Medical History

Please let us know if you take one of the over the counter supplements:

Turmeric **Fish Oil** **CoQ10** **Aspirin 81 MG** **Aspiring 325MG**

(Please Print)

Patient First Name _____ Patient Last Name _____ Date _____

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

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

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Radiation Treatment
☐	☐	Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss
☐	☐	Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis
☐	☐	Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever
☐	☐	Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism
☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever
☐	☐	Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles
☐	☐	Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease
☐	☐	Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble
☐	☐	Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida
☐	☐	Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease
☐	☐	Breathing Problems	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs
☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease
☐	☐	Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw or Joints	☐	☐	Tumors or Growths
☐	☐	Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers
☐	☐	Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease
									☐	☐	Yellow Jaundice

Have you ever had any serious illness not lsited? YES ☐ If yes _____

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:_____