

MEDICAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

Although medical 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 into relationship with the dentistry you will receive. Thank you for answering the following.

- Are you under a physician'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 medications, pills, or drugs? Yes No If yes, please explain _____
- Do you take, or have you taken, Phen-Ben or Redux? Yes No
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing Bisphosphonates? Yes No
- Are you on a special diet? Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

WOMEN: Are you pregnant/*Trying to get pregnant*? Yes No • Taking oral contraceptives? Yes No • Nursing? Yes No

Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain _____

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

- | | | | | | |
|---------------------------|--|---------------------------|--|----------------------------|--|
| AIDS HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitrol Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| artificial joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickel Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenial Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortizone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Easily winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Have you ever had any serious illness not listed above? Yes No If yes, please describe _____

Comments _____

To the best of my knowledge, the questions on this form of 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 Caldwell Dental of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____