Medical History

Major Operations or Hospitilizations _____

Women are you- Pregnant Trying To Get Pregnant Nursing Taking Oral Contaceptives

*If you are pregnant we MUST have a consent form from your OB/GYN prior to your dental appointment

Please list any medications you are currently taking _____

Have you ever taken any of the following medications? Phen-Fen, Redux, Fosamax, Boniva, Actonel or medications containing Bisphosphonates? If yes, please explain _____

Are you allergic to any of the following- **Aspirin** **Metal** **Penicillin** **Latex** **Codeine** **Sulfa Drugs** **Acrylic** **Local Anesthetics**

Other Allergies (**Including Food Allergies**) _____

Have you been diagnosed with Sleep Apnea? If yes, do you wear an appliance? _____

Please circle **YES or NO** if you **have** or **have had** any of the following medical conditions-

AIDS/HIV POSITIVE	YES	NO	CORTISONE MEDICINE	YES	NO	HERPES	YES	NO	RHEUMATIC FEVER	YES	NO
ALZHEIMER'S DISEASE	YES	NO	DIABETES	YES	NO	HIGH BLOOD PRESSURE	YES	NO	RHEUMATISM	YES	NO
ANAPHYLAXIS	YES	NO	DRUG ADDICTION	YES	NO	HIGH CHOLESTEROL	YES	NO	SCARLET FEVER	YES	NO
ANEMIA	YES	NO	EMPHYSEMA	YES	NO	HIVES OR RASH	YES	NO	SHINGLES	YES	NO
ANGINA	YES	NO	EPILEPSY/SEIZURES	YES	NO	HYPOGLYCEMIA	YES	NO	SICKLE CELL DISEASE	YES	NO
ARTHRITIS/GOUT	YES	NO	EXCESSIVE BLEEDING	YES	NO	IRREGULAR HEARTBEAT	YES	NO	SINUS TROUBLE	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	EXCESSIVE THIRST	YES	NO	KIDNEY PROBLEMS	YES	NO	SPECIAL DIET	YES	NO
ARTIFICIAL JOINT	YES	NO	FAINTING SPELLS/DIZZINESS	YES	NO	LEUKEMIA	YES	NO	SPINA BIFIDA	YES	NO
ASTHMA	YES	NO	FREQUENT COUGH	YES	NO	LIVER DISEASE	YES	NO	STOMACH/INTESTINAL DISEASE	YES	NO
BLOOD DISEASE	YES	NO	FREQUENT HEADACHES	YES	NO	LOW BLOOD PRESSURE	YES	NO	STROKE	YES	NO
BLOOD TRANSFUSION	YES	NO	GLAUCOMA	YES	NO	LUNG DISEASE	YES	NO	SWELLING LIMBS	YES	NO
BREATHING PROBLEMS	YES	NO	HEAD/NECK INJURIES	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	THYROID DISEASE	YES	NO
BRUISE EASILY	YES	NO	HEART ATTACK/FAILURE	YES	NO	OSTEOPOROSIS	YES	NO	TOBACCO HABIT	YES	NO
CANCER	YES	NO	HEART MURMUR	YES	NO	PAIN IN JAW JOINTS	YES	NO	TONSILLITIS	YES	NO
CHEMOTHERAPY/RADIATION	YES	NO	HEART PACEMAKER	YES	NO	PREMEDICATION	YES	NO	TUBERCULOSIS	YES	NO
COLD SORES/FEVER BLISTERS	YES	NO	HEART TROUBLE/DISEASE	YES	NO	PSYCHIATRIC CARE	YES	NO	TUMORS/GROWTHS	YES	NO
CONGENITAL HEART DISORDER	YES	NO	HEMOPHILIA	YES	NO	RECENT WEIGHT LOSS	YES	NO	ULCERS	YES	NO
CONTROLLED SUBSTANCES	YES	NO	HEPATITIS A B OR C	YES	NO	RENAL DIALYSIS	YES	NO	VENEREAL DISEASE	YES	NO

MEDICAL CONDITIONS NOT LISTED ABOVE _____

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 _____ Relationship to Patient _____