Medical History

Please check all boxes that apply:

☐ I am under a doctor's care right now.
☐ I have been hospitalized for a surgical procedure or serious illness: _____
_____
☐ I have had a serious head or neck injury: _____
☐ I am taking the following medications: _____
_____
☐ I have been told to pre-medicate prior to my dental visits.
☐ I have taken Fosamax, Boniva, Actonel, or any cancer medication containing bisphosphonates before.
☐ I use tobacco.
☐ I am currently on blood thinners.
☐ I am on a special diet: _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin or Amoxicillin ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic ☐ Any metal (nickel, mercury, etc.) ☐ Latex
☐ Other: _____

Are you currently: ☐ Taking oral contraceptives? ☐ Pregnant? ☐ Nursing?

I have/have had the following:

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

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnoses and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient (or parent/guardian): _____ Date: _____