Bayview DENTAL

MEDICAL HISTORY

Name: ____Birth Date: ______________

Are you under a physician's care now? Yes/No. If Yes: _______________________________
____

Have you ever been hospitalized or has 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, supplements, or over the counter medications? Yes/No. If Yes: ____
____

Do you take or have you taken Phen-Ren or Redux? Yes/No. If Yes: _____________________

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Yes/No. When: ____

Are you on a special diet? Yes/No. If Yes: ______________________________________

Do you use tobacco? Yes/No. If Yes: ____

Do you use controlled substances? Yes/No. If Yes: __________________________________

WOMEN (only):

Are you pregnant? Yes/No

Nursing? Yes/No

Taking oral contraceptives? Yes/No

Are you **ALLERGIC** to any of the following?

Aspirin: Yes/No

Penicillin: Yes/No

Amoxicillin: Yes/No

Codeine: Yes/No

Latex: Yes/No

Sulfa drugs: Yes/No

Local anesthetics: Yes/No

Other:____

OVER ------------→

MEDICAL CONDITIONS	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive			Alzheimer's Disease			Anaphylaxis			Anemia		
Angina/Chest Pain			Arthritis/Gout			Artificial Heart Valve			Artificial Joint		
Asthma			Blood Disease			Blood Transfusion			Breathing Problem		
Bruise Easily			Cancer			Chemotherapy			Cold Sores/Fever Blisters		
Convulsions			Cortisone Medication			Diabetes			Drug Addiction		
Easily Winded			Emphysema			Epilepsy or Seizures			Excessive Bleeding		
Excessive Thirst			Fainting Spells/Dizziness			Frequent Cough			Frequent Diarrhea		
Frequent Headaches			Glaucoma			Hay Fever			Heart Attack/Failure		
Heart Murmur			Hemophilia			Hepatitis A			Hepatitis B or C		
Herpes			High Blood Pressure			High Cholesterol			Hypoglycemia		
Irregular Heartbeat			Kidney Problems			Leukemia			Liver Disease		
Low Blood Pressure			Lung Disease			Mitral Valve Prolapse			Osteoporosis		
Pacemaker			Pain in Jaw Joints			Parathyroid Disease			Psychiatric care		
Radiation Treatments			Renal Dialysis			Rheumatic Fever			Rheumatism		
Scarlet Fever			Shingles			Sickle Cell Disease			Stomach/ Intestinal Disease		
Stroke			Swelling of Limbs			Thyroid Disease			Tonsillitis		
Tuberculosis			Tumor/Growths			Ulcers					
Additional Comments:											

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing the incorrect information for withholding information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian: ______________________________
Date: ______________________________