Med hx 6/2020

Patient Name: Birth Date: Date Created:

Name of Primary Care Physician:	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever taken bisphosphonates such as Fosamax? (Often used for osteoporosis)	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	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

Do you use tobacco? How much per week?	◯ Yes ◯ No	If yes	
Do you use any controlled substances?	◯ Yes ◯ No	If yes	

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

☐ AIDS/HIV positive	☐ High Blood Pressure
☐ Alzheimer's Disease	☐ Hepatitis B/C
☐ Arthritis/Gout	☐ High Cholesterol
☐ Artificial Heart Valve	☐ Irregular Heartbeat
☐ Artificial Joint	☐ Kidney Problems
☐ Asthma	☐ Leukemia
☐ Blood Disease	☐ Liver Disease
☐ Blood Thinners	☐ Lung Disease
☐ Cancer	☐ Mitral Valve Prolapse
☐ Chemotherapy	☐ Osteoprosis
☐ Chest Pains	☐ Pacemaker
☐ Clotting Disorder	☐ Pain in Jaw Joints
☐ Congenital Heart Disorder	☐ Psychiatric Care
☐ COPD	☐ Radiation Treatments
☐ Diabetes	☐ Sickle Cell Disease
☐ Dialysis	☐ Sinus Trouble
☐ Drug Addiction	☐ Stomach/Intestinal Disease
☐ Emphysema	☐ Stroke
☐ Epilepsy or Seizures	☐ Thyroid Disease
☐ Fainting Spells/Dizziness	☐ Tuberculosis
☐ Glaucoma	☐ Tumors or Growths
☐ Heart Attack/Disease	☐ Ulcers
☐ Heart Murmur	☐ Venereal Disease

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes	

Comments:

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:_____