SmileDental CENTER

MEDICAL HISTORY

Patient: _____

Although dental 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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

			If your answer is yes please specify:
Are you under a physician's care now?	YES	NO	
Have you ever been hospitalized or had a major operation?	YES	NO	
Have you ever had a serious head or neck injury?	YES	NO	
Are you taking any medications, pills, or drugs?	YES	NO	
Do you take , or have you taken, Phen-Fen or Redux?	YES	NO	
Do you take or have you taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?	YES	NO	
Are you on a special diet?	YES	NO	
Do you use tobacco?	YES	NO	

Are you allergic to any of the following?

☐ Aspirin ☐ Metal ☐ Penicillin ☐ Latex ☐ Codeine ☐ Sulfa Drugs ☐ Acrylic

☐ Local Anesthetics ☐ Other: _____

Do you use controlled substances? ☐ Yes _____ ☐ No

<u>WOMEN</u>: Are you…

☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

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MEDICAL HISTORY

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

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive			Excessive Thirst			Mitral Valve Prolapse		
Alzheimer's Disease			Fainting Spells/Dizziness			Osteoporosis		
Anaphylaxis			Frequent cough			Pain in Jaw Joints		
Anemia			Frequent Diarrhea			Parathyroid Disease		
Angina			Frequent Headaches			Psychiatric Care		
Arthritis/Gout			Genital Herpes			Radiation Treatments		
Artificial Heart Valve			Glaucoma			Recent Weight Loss		
Artificial joint			Hay fever			Renal Dialysis		
Asthma			Heart Attack/Failure			Rheumatic Fever		
Blood disease			Heart murmur			Rheumatism		
Blood Transfusion			Heart Pacemaker			Scarlet Fever		
Breathing Problems			Heart Trouble/Disease			Shingles		
Bruise easily			Hemophilia			Sickle Cell Disease		
Cancer			Hepatitis A			Sinus Trouble		
Chemotherapy			Hepatitis B or C			Spina Bifida		
Chest pains			Herpes			Stroke		
Cold sores/Fever Blisters			High Blood Pressure			Stomach/Intestinal Disease		
Congenital Heart Disorder			High Cholesterol			Swelling of Limbs		
Convulsions			Hives or Rash			Thyroid Disease		
Cortisone Medicine			Hypoglycemia			Tonsillitis		
Diabetes			Irregular Heartbeat			Tuberculosis		
Drug addiction			Kidney Problems			Tumors or Growths		
Easily Winded			Leukemia			Ulcers		
Emphysema			Liver Disease			Veneral Disease		
Epilepsy or Seizures			Low Blood Pressure			Yellow Jaundice		
Excessive Bleeding			Lung Disease					

Have you ever had any serious illness not listed? ☐ Yes ☐ No

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 _____ Date ____/____/____