MEDICAL HISTORY

NAME:______________________________________ DOB:_____________ Phone: Hm________________ C____________________

Address:____Zip Code:___________________________

Name relative/friend:____________________________ Relation:______________ PHONE:__________________________________

Do you have a primary care Dr? No ***YES*** : Name & number:____

Have you been hospitalized or had a major operation in the last 6 mos?:____

Have you ever had a serious head or neck injury?:____

Do you have an artificial joint or heart valve? No ***IF YES*** : Dr,date,site:____

Are you or have you ever taken biophosphonate meds for osteoporosis? ____

Are you taking any medications? No ***IF YES, please LIST MEDS:***____

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Do you have pain or popping in your jaws? ________ Do you clench or grind your teeth?________ Do your gums bleed?_________

How often do you brush your teeth?_______________________ Do you floss and how often?_____________________

Women: Are you pregnant? Y N Trying to get pregnant? Y N Nursing? Y N

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

Aspirin Y N	Penicillin Y N	Codeine Y N	Acrylic Y N
Metal Y N	Latex Y N	Sulfa Drugs Y N	Local Anesthetics Y N

Are you allergic to anything else not listed above? N Yes please list:____

Do you use tobacco in any form? N Yes type & frequency: ____

Do you have or had any of the following:

HIV/AIDS+	Y N	Diabetes	Y N	Arthritis	Y N	Epilepsy/seizure	Y N
Hepatitis	Y N	Kidney Problems	Y N	Osteoporosis	Y N	Frequent Headaches	Y N
Rheumatic Fever	Y N	Renal Dialysis	Y N	Leukemia	Y N	Convulsions	Y N
Heart Attack	Y N	High Blood pressure	Y N	Cancer	Y N	Ulcers	Y N
Pacemaker	Y N	Low Blood pressure	Y N	Chemotherapy	Y N	Stomach/intestinal DX	Y N
Heart Disease	Y N	Asthma	Y N	Radiation TX	Y N	Recent Weight Loss	Y N
Artificial heart valve	Y N	Lung Disease	Y N	Blood Transfusion	Y N	Bruise Easily	Y N
Mitral Valve Prolapse	Y N	Tuberculosis	Y N	Hemophilia	Y N	Low Blood Sugar	Y N
Congenital heart dx	Y N	Frequent Cough	Y N	Excessive Bleeding	Y N	Scarlet Fever	Y N
Chest Pain	Y N	Sinus Trouble	Y N	Thyroid Disease	Y N	Shingles	Y N
Irregular Heart Beat	Y N	Glaucoma	Y N	Liver Disease	Y N	Hives/Rash	Y N
High Cholesterol	Y N	Hard of hearing	Y N	Alzheimer's DX	Y N	Cold Sores/fever blisters	Y N
Stroke	Y N	Impaired Sight	Y N	Fainting/dizzy spells	Y N	Drug Addiction	Y N

Have you ever had any serious illness not listed? Y N If Yes, please list:____
Do you wear a CPAP machine for sleep apnea? Y N

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

X____ Date:___________________________