New Baltimore Family Dentistry

Medical History

HEALTH HISTORY

First Name		Last Name		Birth Date	

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.

Are you under a physician's care now?	❑ Yes	❑ No
If yes, please describe		
Have you ever been hospitalized or had a major operation?	❑ Yes	❑ No
If yes, please describe		
Have you ever had a serious head or neck injury?	❑ Yes	❑ No
If yes, please describe		
Are you taking any medications, pills, or drugs?	❑ Yes	❑ No
If yes, please list		
Do you take, or have you taken, Phen-Fen or Redux?	❑ Yes	❑ No
If yes, please describe		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	❑ Yes	❑ No
If yes, please list		
Are you on a special diet?	❑ Yes	❑ No
Do you use tobacco?	❑ Yes	❑ No
Do you use controlled substances?	❑ Yes	❑ No
If yes, please list		

FOR WOMEN ONLY

Are you...	❑ 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 have any other allergy not listed above?	❑ Yes	❑ No
If yes, please list		

DO YOU HAVE OR HAVE YOU EVER 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		

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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**			**Stomach/Intestinal Disease**		
Cold Sores/ Fever Blisters			**High Blood Pressure**			**Stroke**		
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**			**Venereal Disease**		
Epilepsy or Seizures			**Low Blood Pressure**			**Yellow Jaundice**		
Excessive Bleeding			**Lung Disease**					

Have you ever had any serious illness not listed? If yes, please list below.	❑ Yes	❑ No

COMMENTS:

FORM COMPLETION

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**	

IF PATIENT IS A MINOR

Form signed by		**Relationship to Patient**	

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